

Columbia College Chicago Digital Commons @ Columbia College Chicago

Creative Arts Therapies Theses

Thesis & Capstone Collection

12-2010

The Emotional Road to Recovery: Tracking the Mind and Body Experience of Shame in Women Recovering From Drugs and Alcohol

Nicole DiBacco
Columbia College - Chicago

Follow this and additional works at: http://digitalcommons.colum.edu/theses_dmt



Part of the [Dance Movement Therapy Commons](#)



This work is licensed under a [Creative Commons Attribution-Noncommercial-No Derivative Works 4.0 License](#).

Recommended Citation

DiBacco, Nicole, "The Emotional Road to Recovery: Tracking the Mind and Body Experience of Shame in Women Recovering From Drugs and Alcohol" (2010). *Creative Arts Therapies Theses*. Paper 24.

This Thesis is brought to you for free and open access by the Thesis & Capstone Collection at Digital Commons @ Columbia College Chicago. It has been accepted for inclusion in Creative Arts Therapies Theses by an authorized administrator of Digital Commons @ Columbia College Chicago.

THE EMOTIONAL ROAD TO RECOVERY:
TRACKING THE MIND AND BODY EXPERIENCE OF SHAME
IN WOMEN RECOVERING FROM DRUGS AND ALCOHOL

Nicole DiBacco

Thesis submitted to the faculty of Columbia College Chicago

in partial fulfillment of the requirements for

Master of Arts

in

Dance/Movement Therapy & Counseling

Dance/Movement Therapy and Counseling Department

December 2010

Committee:

Susan Imus, MA, BC-DMT, GLCMA, LCPC
Chair, Dance/Movement Therapy and Counseling

Lenore Hervey, PhD, BC-DMT, NCC, REAT
Research Coordinator

Laura Allen, MA, BC-DMT, LPC
Thesis Advisor

Abstract

The purpose of this thesis project was to identify the emotional experiences of women who are in recovery for addiction on a verbal and non-verbal level and determine if shame is a predominant emotion. Through the combination of phenomenological and clinical case study methodologies, this thesis examines the verbal disclosures and movement responses of women within dance/movement therapy groups, through video recording and journal entries. Content analysis resulted in the identification of primary themes, which included circumstances related to relationship and responsibility, shame related to responsibility, goals for their relationships and for self. The resulting implications for dance/movement therapy methods to address the needs of this population are presented as well as questions for further research.

Acknowledgments

I would like to thank my thesis advisor, Laura Allen for her continued guidance, feedback and advising throughout the process of this project.

My deep appreciation to my Internship supervisor Kim Pinkston for her guidance, support and advocacy she offered during the preparation of my thesis groups as well as for her assistance with the video work for this project.

My gratitude is extended to Lynnette Barnier and Mary Lane for their encouragement, feedback and support throughout the writing of this thesis.

I would like to thank the wonderful ladies who participated in this study for their openness and willingness to engage in this process, without whom this thesis would not be possible.

And finally, I would like to honor my mom, Nancy McDermott, a strong woman dedicated to helping others, who continually supports and inspires my personal growth and achievements.

Table of Contents

	Page
CHAPTER ONE: INTRODUCTION	1
CHAPTER TWO: LITERATURE REVIEW.....	6
CHAPTER THREE: METHODS.....	26
CHAPTER FOUR: RESULTS.....	32
CHAPTER FIVE: DISCUSSION.....	49
REFERENCES	72
APPENDICES	
Appendix A: Definition of Terms	78
Appendix B: Informed Consent Form.....	82
Appendix C: Authorization Release of Information for Research	86
COLUMBIA COLLEGE CHICAGO ELECTRONIC THESIS AGREEMENT	87

Chapter One: Introduction

The purpose of this thesis project was to identify the emotional experiences of women who were in treatment for addiction and determine if shame was a predominant emotion. In order to gather this information, I observed their bodies, their movement, and verbal disclosures in the context of dance/movement therapy groups (see appendix A). I led dance/movement therapy (DMT) sessions at a treatment center for drugs and alcohol, as an intern, where I experienced many challenges with the women clients. To me, they appeared to carry heavy burdens that are unique to a woman's gender specific experience. In turn, I became increasingly interested in the emotions that were associated with or may have contributed to the burdens women experience as a result of their addiction. The current research described shame as a predominant emotional experience in women who are in treatment for addiction. Therefore, this study set out to identify the experience of shame within women in recovery for drugs and alcohol on a verbal and non-verbal level.

The question that this thesis project intended to answer was "Is shame a predominant emotion experienced in women during recovery from addiction?" The subsequent question is, how is shame seen and expressed in women during the treatment process of addiction? Larger questions to which this project may contribute are: do similar emotional experiences exist among women in treatment for addiction? Are there other predominant emotions expressed by women in treatment? How can DMT be used to address shame and addiction? And finally, how does the social/cultural construct of gender roles contribute to the women's emotional experiences in the treatment process?

By asking these questions, I would like to address the shame women may experience surrounding the social roles imposed upon them (including victimization through sexual and

domestic abuse), which perpetuate the negative cycle of addiction. Asking these questions is crucial for understanding women's emotional experience, in order to make appropriate conclusions for treatment goals, both through movement and addressing the life factors that contribute to the women's addiction pattern.

In approaching my thesis project, I used an existential-humanistic perspective. This theoretical framework allowed me to meet and support the participants in my groups exactly where they were. I did not try to lead them in any direction that they were not naturally going on their own, but joined and supported the women in their current experiences. This framework supported my project as a clinical case study/phenomenological study as it gave a pure account of the emotional experiences the women in my groups experienced without manipulating the variables that produced their responses.

Literature Support

The current state of research revealed that women experience a greater sense of shame and social stigma about their chemical dependence than do men, and suffer, as well, from more intense feelings of self-hatred and mistrust (Murray-Lane, 1995). Babcock and Connor (1981) also state that women internalize a greater negative self-image due to their alcoholism, bringing an increased burden of guilt and low self-esteem to treatment. Furthermore, Fuhlrodt (1990) finds that women are more able than men to identify the painful causes of their addiction. In addition, they blame themselves for their disease regardless of their life situations. They are also secretive about their addiction, which creates a vicious cycle.

The term addiction in this thesis refers to a mental health issue described by the DSM as substance dependence (Morrison, 2006) (see Appendix A). The criteria necessary to meet this diagnosis specify a type of dependence that includes behavioral, physiological and cognitive

symptoms. According to the DSM, meeting three or more of the criteria that is described as “the maladaptive pattern of substance use that leads to clinically important distress or impairment, as shown in a single 12-month period” warrants a diagnosis of substance dependence (Morrison, 2006, p. 69). This dependence is characterized by an inability to stop using the substances regardless of the harmful effects it is having upon the women’s lives (Rose, 1995).

Research has shown that one of the most important factors in determining whether a person feels shame or guilt is his or her level of self-esteem. A person’s self-esteem is formed during their childhood through interaction with family members. If a person has high self-esteem they will be likely to separate themselves from a wrongdoing they make and simply feel guilt over that action. Additionally, if others treat the act and individual as separate then the individual can feel guilt and make amends for their mistakes. If a person has low self-esteem and commits a wrongdoing they will be more likely to feel shame. Likewise, if others do not separate the wrongdoing from the person then the individual will feel shame as he or she internalizes their action, causing them to feel frustrated and humiliated. Overall, guilt can be used to affect positive behaviors or social change while shame can create obedience and give authority to abusive personalities (Atherton, 2010).

For the purpose of this thesis, the term shame will be used to describe the emotion when the women recognize that an act they committed was wrong and subsequently internalized the mistake, believing they were a bad person as a result of their behavior. Additionally, for the purpose of this thesis, the term guilt will be used to describe the emotion felt when the women recognize that an act they committed was wrong and consequently felt badly about that act (Articles, 2010).

Shame is found to be a primary, gender-specific emotional experience in women with addiction (Wiechelt, 2008). To explore these findings, this study identified the emotional experiences of women recovering from drugs and alcohol. This identification was accomplished through the examination of the emotional experiences presented by the women within the groups to determine the most prevalent emotions they experienced. Furthermore, the often confused emotions of shame or guilt were explored to determine which was most prevalent for the women. This study also shed light on the situations in the women's lives that contributed to their shame or guilt as well their addiction.

In terms of the social-cultural construct of gender roles, women are often the primary caretakers of their children. Consequently, this disproportionate distribution of responsibility may contribute to the shame women experience when suffering from their addiction and are not able to care for their children (Chudley, et al., 2005). Additionally, the question of whether the social-cultural construct of gender roles influenced the experience of shame in women with addiction was explored.

Looking closer at the emotional experiences of women recovering from addiction in order to understand the contributing factors to their addiction and possibly their shame, brings clinicians one step closer toward understanding how to effectively treat women's issues. Particularly, gaining a deeper understanding of the causes of shame and addiction in women may help clinicians address these issues through movement interventions. Overall, this examination will contribute knowledge about the emotional experience of shame in women undergoing treatment for addiction. This knowledge will therefore benefit the clients by improving clinicians' ability to treat women recovering from addiction.

In the following chapter, I will discuss the current literature pertaining to addiction, DMT, shame and women. This discussion will specifically explore the connections between DMT and addiction, addiction and shame and women and addiction.

Chapter Two: Literature Review

Within the framework of this study, literature relating to the use of dance/movement therapy (DMT) to treat addiction will be reviewed as a way to draw connections between this form of creative arts therapy and the effects it may have upon individuals in recovery. Included within the information pertaining to DMT are clear examples of how DMT can be utilized within a treatment environment. The areas of focus are feelings, body awareness, movement as a metaphor, group structure and the way in which DMT can be paired with Alcoholics Anonymous (AA). The manner in which shame manifests with addiction becomes a focal point for exploration within this review. The research relating to the internalization and deflection of this shame is thus explored as this gives greater insight into the resulting behavioral responses that perpetuate the addictive cycle. Further research on the topic of addiction and shame has revealed that an area of neglect has been the unique needs and considerations of women. The implications and causes of addiction within women as well as treatment outcomes are investigated with regard to the gender-specific needs of the substance abuse population. Although more recent attention has been brought to this issue, it is just the beginning of a long line of work necessary to understand and fully address the multifaceted needs of women, shame and addiction.

DMT and Addiction

Benefits of DMT with addiction. Many authors believe individuals recovering from addiction have a lot to gain from the use of DMT. To begin, Milliken (1990) pointed out that “DMT offers a highly effective and unique approach to dealing with the substance abuser’s characteristic resistance, denial, isolation, and low self-esteem” (p. 309). Johnson (1990) drew from her personal experience working with alcoholics to claim that miracles happen when addicts open themselves and discover the beauty of their inner nature through their creativity.

Breslin, Malone and Reed's (2003) research article outlines the benefits of various holistic and interdisciplinary approaches to substance abuse treatment. From his analysis, he concludes that DMT is one of the modalities that is helpful in offering a diverse program for substance abuse treatment.

Connection to feelings. According to Breslin, "DMT sessions help individuals experience bodily sensations that may be linked to specific feelings" (2003, p. 248). He suggested that DMT offers an opportunity to manage stress in a healthier way, as many patients describe a renewed ability to relax without the use of alcohol or drugs. Fisher (1990) believed that providing a safe environment for individuals to access their feelings is important because "these feelings may be unfamiliar to many patients because they have been blocked by denial" (p. 231). As a result, difficult feelings such as anger, shame, loss, and depression can be expressed in a safe, nonverbal manner. This leads to the ability to express feelings verbally and contributes to the healing process.

Continuing with this idea of emotional connections, Baker, Dingle and Gleadhill (2007) introduced the idea that repeatedly exposing individuals to their different emotional states, in the absence of substance use allows them to learn that they can tolerate these emotions. Milliken (1990) explained this idea by additionally pointing out that "DMT provides a context to re-experience the self without chemicals in the system and to develop a tolerance for that feeling" (p. 312). It is very important for individuals with addiction to learn how to deal with their emotions as Baker, Dingle, and Gleadhill pointed out that negative mood states increase drug cravings.

Body awareness. Milliken (1990) supported the notion that DMT is effective in working with addiction by specifically discussing the non-verbal, body oriented approach of DMT. She

explained how this approach is extremely useful in addressing the substance abuser's lack of body awareness by "identifying the underlying issues and allowing for safe expression of affect" (p. 309).

This concept is supported by Fisher (1990) who stated that the manner in which a patient is unable to take the first step is felt and seen in the body and is an obvious advantage of DMT. Milliken continued to describe the common experiences of affect, defenses, rage, fear of closeness, and movement features of substance abusers. After which she outlined how these experiences can be addressed within the goals and structure of a DMT group. Relating directly to the body and the fear of closeness, Milliken (1990) has observed postural reflections of this fear in a frequently narrowed or rigid stance. She stated that the active movement related to this fear is displayed as "controlled, non-spontaneous, and jerky" (p. 311).

Movement as a metaphor. In keeping with Milliken's (1990) concept of feelings, Rose (1995) takes the representations of the body, described above, another layer deeper by describing how movement can be used as a metaphor to bring awareness to one's behavior and feelings. She tests this theory within a dynamic short-term treatment for addiction. The four areas Rose focused upon were self-esteem, feelings, relationships and self-care. She concluded that only by learning to identify, tolerate and process feelings, can a chemically addicted person learn to recover. Based on her theory and experience, she states that "dance as art or therapy enables the representation of experience through symbols" (p. 103).

Similarly, Schmais (1998) added, "The metaphoric symbol can externalize the internal state" (p. 29). The clinical case vignettes Rose (1995) used to describe the experience of a movement therapy group demonstrated how a dance/movement therapist can empower and guide the patient to find their own connections by bringing awareness to the parallels his or her

movement may have to his or her behavior in daily life. For example, "a severely slumped body may represent depression, whereas feet that feel glued to the floor provide an apt metaphor for feeling stuck in one's life" (p. 103).

By suggesting that dance is a metaphor for addiction, Perlmutter (1992) added to Rose's metaphoric examples. She made the claim that, "addiction, like dance, is a dynamic process. Addiction is not static. It moves. It develops its own rhythm, form and meaning. It progresses. It retreats" (p. 43). Likewise, she also compares the 12-steps of recovery to the steps of a dance by stating that in order to recover, the addict must move and take steps from where he is, to somewhere else, just like when one is dancing.

Group structure. In DMT, as in other therapy groups, the process of moving from one stage to the next can be very difficult and require a lot of patience. Schmais (1998) leads us into the group structure of DMT by breaking down the stages of a therapy group with clients recovering from addiction. The stages she focused upon, which differ from theorist to theorist, include: affiliation, differentiation, intimacy and separation. She stated that to meet the needs of the patients, the task of a dance/movement therapist is to be "in continuous action, reflecting and modeling behaviors that move a group towards goals such as expression, individuation, empowerment, socialization, and cohesion" (Schmais, 1998, p. 23).

Excerpts from a group DMT session were offered by Schmais (1998) to illustrate the usefulness of this knowledge to the therapist's processing of the group. Schmais discussed the benefits offered and needs being met through the development of each of these stages. In specifically addressing the affiliation stage of a DMT group, Schmais supported others' claims that exchanging whole body movement helps build relationship. Schmais builds on this idea by stating:

On the emotional level, the task is to enable patients to share different movement dynamics--the substance of expressive movements--different facial expressions, and to experience different moods. On the social level, the task is to reduce isolation by providing opportunities for interaction, moving towards each other, looking at each other, making common sounds, greeting each other. (p. 28)

The pairing of DMT with AA. Fisher (1990) provided evidence for how DMT can be effectively applied within a substance abuse program, specifically within the AA Twelve Step model. Data collected from the DMT experiences of several individuals in their AA treatment were represented through clinical examples of the individuals' experienced emotional issues.

Following is a specific clinical example of a patient who was able to overcome blocks she had experienced in verbal groups:

This was the second time Suzanne had been in treatment. She was a nurse, about 45 years old. She felt she knew the program well and she was unwilling to do much talking in verbal groups. In every DMT group when she focused on her own bodily feelings, she was brought to tears. As time progressed she was able to share her overwhelming sense of guilt, fear, and embarrassment at the realization that she could not conquer her disease alone. Suzanne was taking her 'First step' in a new deeper way. (Fisher, 1990, p. 328)

In supporting the use of creative therapies with AA, Johnson (1990) compared the twelve steps of recovery to a rebirth by suggesting that this rebirthing implies the death of the false-addicted self, the "ego," and the discovery of the true self or the "Self" (p. 300). She continued to state "the 'ego-self' is associated with defensiveness and attachment, while the "Self" is associated with creativity and love" (p. 300).

Similarly, Fisher (1990) continued to make connections between DMT and AA by

relating the first step of powerlessness to the creative process, a “transliminal state of mind” (p. 327). She described this state as being an experience where "one is free of censorship, off guard, relaxed, and yet receptive" (p. 327). Ghiselin (1954) presented the idea that individuals tap into their unconscious when they create and that change is easier from this place, because the compulsive and inhibiting effects on the system supported by will and attention are minimized.

In keeping with the statements of the previous authors, Fisher (1990) concluded that the combination of DMT with AA is effective in the treatment of addiction as it addresses the underlying psychopathology needs. Additionally, she concluded that DMT helps provide support, improve self-esteem, and is an aid in the exploration of alternative approaches to dealing with life circumstances. Finally, it is important to note that from the client's perspective, DMT has led to increased satisfaction with their treatment experience (Breslin et al., 2003).

Addiction and Shame

Addiction. As presented in the previous chapter, what is referred to in this thesis as addiction is a mental health issue described by the DSM as substance dependence (Morrison, 2006). The criteria necessary to meet this diagnosis specify a type of dependence that includes behavioral, physiological and cognitive symptoms. Substance Dependence is defined in the same terms as are used for many other non-substance-related Axis I disorders. According to the DSM, in order for substance use to be considered a mental health issue, an individual must experience three of the following criteria:

Increased tolerance for the substance, withdrawal from the substance or use of the substance to relieve withdrawal, an amount or duration of use that is often greater than intended. The patient must repeatedly try without success to control or reduce substance use. The patient spends much time using the substance, recovering from its effects, or

trying to obtain it. The patient reduces or abandons important work, social, or leisure activities because of substance use. The patient continues to use the substance, despite knowing that it has probably caused ongoing physical or psychological problems. Clinically speaking if the substance abuse problem is serious enough to interfere somehow with the person's life, it is categorized as a mental health issue. (Morrison, 2006, p. 96)

Shame. In considering the role shame has on addiction, it is important to understand shame as described by authors who write about this relationship. Wermser (1994) characterized shame as “a ‘betrayal’ of a global or gestalt image of the self because it is a threat to the whole framework of one's identity” (p. 19). According to Ahmed (2001), shame is thought to encompass feelings of inadequacy, inferiority, humiliation, dishonor, and a sense of despair and deep suffering. Lewis' (1971) definition of shame involves a universal negative feeling about the self in response to some wrongdoing.

Distinction between shame and guilt. To provide an even greater understanding of shame, it is important to also draw the distinction between the two emotions of shame and guilt due to the differing implications they present in relation to an addictive disorder. These terms are often wrongly used interchangeably. Lindsay-Hartz, de Rivera and Mascolo (1995) state that feelings of shame can be painful and paralyzing, affecting one's sense of self. These feelings of shame may also invoke a self-defeating cycle of negative affect and substance abuse as the individual struggles to dampen this painful feeling with drugs and alcohol. On the other hand, feelings of guilt are less impacting than shame and can even motivate the individual toward repairing or changing their situation (Dearing, Stuewig & Tangney, 2005).

Using this critical self/behavior distinction between shame and guilt, research has shown

that shame-prone individuals are vulnerable to a variety of difficulties, including psychological problems and low self esteem. Because the focus of shame is on the defective self, this painful emotion also has the effect of impairing empathy, which can result in a wide range of interpersonal difficulties (Dearing et al., 2005).

Shame-proneness vs. guilt-proneness. Dearing, Stuewig and Tangney (2005), sought to clarify the relations of shame-proneness and guilt-proneness to addictive behaviors in three studies drawing from two very different populations--college students and incarcerated jail inmates. The results revealed "shame-proneness shows a significant positive relation to drug problems and a stronger positive relation to alcohol problems. Conversely, guilt-proneness has been shown to have a negative relation to alcohol and drug problems" (Dearing et al., 2005, p. 1396). These findings are consistent with other studies, which show shame to be positively correlated to drug and alcohol use. In keeping with the notion that coping with negative emotions is a motivator for substance abuse, it is very likely that shame-prone individuals use alcohol or drugs as a strategy for coping with difficult feelings of shame (Dearing et al., 2005).

Correlation between shame and addiction. Throughout the literature reviewed, there are consistent findings that addiction and shame are directly related. This is supported by Dearing, Stuewig & Tangney's (2005) statement that, "Among the emotional factors implicated in substance use problems, the tendency to experience shame is mentioned often, typically in conjunction with discussions of treatment" (p. 1393).

Additionally, Fossum and Mason (1986) proposed that addiction and shame cannot be separated. This belief is further supported by the above referenced research findings of Dearing, Stuewig, and Tangney (2005), which showed that there is a positive correlation between substance use problems and shame-proneness.

The effects of shame on addiction.

Internalizing shame. Bradshaw believed that at the core of addictive behaviors is a condition he calls “toxic shame, the sense of experiencing oneself as flawed and defective as a person. Therefore, perceiving oneself as inferior to others and alienated from self and others, as well as being afraid of revealing oneself as vulnerable, are described as motives for using drugs” (as cited in Wiklund, 2008, p. 2426). There is a direct correlation between Wermser's (1994) description of shame as a negative perception or betrayal of self and Lindsay-Hartz, de Rivera and Mascolo's (1995) research revealing that the use of drugs changes perceptions of self. This also relates to Boyd & Mackey's (2000) claim that the goal of using drugs is to provide a means to escape psychological pain.

According to Stofle (1999), these feelings of shame and guilt appear to be related to the human conscience as the person struggles with what is and what ought to be. Thus, addicted people have a difficult time making decisions, knowing the trouble the abuse causes, but also the relief it provides.

With the intention of supporting the existing existential theory, Wiklund (2008) conducted a secondary analysis of narrative data that described the struggle of suffering in addiction as a struggle between shame and dignity as well as with life. The first phase of the text analysis guided by a hermeneutic approach was a rational interpretation, often described as good-reason-essay, aiming to understand the person's motive for acting. The next phase involved structural interpretation. In this phase, the research object is studied more closely with focus on specific situations, events and actions. The last phase is existential interpretation and at this level interpretation focuses on the existential world as the world of the text.

The findings follow the phases of interpretation described above. Within rational

interpretation, the findings show that the motive was to escape suffering, with two themes existing within the findings. The first theme was linked to the more direct capacity of drugs to relieve anxiety and unbearable feelings. The second theme related to the effect the drug had on the person's perception of him/herself as a person. This rational interpretation places focus on the person's good reason—as the use of drugs makes sense to the abuser because it helps him/her to handle feelings of shame and inadequacy (Wiklund, 2008).

The structural interpretation reveals that the addicted individual's ability to function in the world without the perceived strength and/or relief from suffering that drugs offers appears impossible. Because other people do not acknowledge them as individuals when they are not high and then praise them when on drugs, it is hard to quit (Wiklund, 2008).

As far as existential interpretation, findings reveal that the inner picture of oneself as worthless and shameful is a frame of reference that helps the sufferer to create a pattern of meaning. This causes them to organize their experiences accordingly, essentially serving as a self-fulfilling prophecy. Not recognizing one's own feelings makes people become strangers not only to others, but also to themselves. Using drugs and/or alcohol to escape feeling isolated and worthless only perpetuates the cycle of not understanding oneself and feeling rejected by others. "Therefore, these feelings of being rejected lock people into loneliness" (Wiklund, 2008, p. 2429).

Deflecting shame. On the other end of the spectrum, this section will focus on Maruna and Ramsden's (2001) argument that a “social process of narrative reconstruction--similar to what takes place in 12-step meetings every day--provides a means of escape from this chimera of deviance and shame” (p. 131). The authors offer an interesting perspective, proposing that externalizing one's feelings of anger through the escapism of drugs or materialist consumption

are among the options available for deflecting or avoiding shame. According to Nathanson's (1992) compass of shame theory, deviance, shame, and the deflection of shame, then become a never-ending cycle.

Maruna and Ramsden (2001) critically reviewed the traditional understanding of narratives of deviance in criminology and related disciplines. Their examples focused mainly on addiction and recovery, as this is where they felt the narrative perspective has best been developed. Within their exploration, many parallels were drawn between the act of criminal behavior and that of the addictive process.

One of the critical components included in this article, in the section titled: *False Pride and Deviance: Deflecting Shame*, is that much delinquency is based on what is essentially an unrecognized extension of defenses to crimes, in the forms of justifications for deviance. These include "denial of responsibility, denial of injury, denial of the victim, condemnation of the condemners, and appeal to higher loyalty" (Maruna & Ramsden, 2001, p. 133).

In this formulation, "delinquents are thought to embrace conventional moral values but also escape the conscience involved in breaking these rules by then internalizing a system of rationalizations for criminal behavior" (Maruna & Ramsden, 2001, p. 133).

As described previously, the recent existential interpretation findings explained that the sufferer has internalized shame, which creates opportunities for a self-fulfilling prophecy (Wiklund, 2008). In this case of false pride, the authors suggest that the criminals or addicts do the opposite by behaving as though they are invisible and deflecting any shame that may come along with their behaviors. Neutralizing techniques are a form a "shame deflection" to justify why they don't abide by the laws of society and/or to justify why they hurt themselves and/or others. This is all done so they can feel good about themselves despite violating a shared moral

code (Maruna & Ramsden, 2001). In recalling the definition of shame by Wermser (1994) as a negative perception or betrayal of the global self because it is a threat to the whole framework of one's identity, it can be understood why one might rationalize their shameful behavior in order to preserve their sense of self.

In relating this specific example to addiction, it is explained as a disease of epistemology or, in the vernacular of AA, a disease involving stinking thinking. "Habitual drinkers and drug users are thought to deny their addictions (and hence maintain their dignity) through an elaborate sort of 'false pride' characterized by rampant individualism, materialism, and egotism" (Maruna & Ramsden, 2001 p. 133).

Equally, Maruna and Ramsden (2001) believe the addiction is "reinforced by the rampant consumerism of the wider culture" (p. 133). Both the addict and the modern consumer are thought to be in a "state of denial of sorts, masking their shame behind a materialistic veil" (p. 133).

The solution offered in Sharp's (2000) treatment program and others like it is to convince convicts and addicts to internalize responsibility for their actions. As a means to shame management, Maruna and Ramsden (2001) believe "the focus is to unmask offenders, tear down their well-developed defense mechanisms, and shine the mirror of reality at them, confronting them with the shame of their lives" (p. 134).

Women and Addiction

Unique considerations for women. Women's substance use behaviors are affected by a number of potential mediating and moderating factors. "They vary across time, cultures, ethnicities, social roles, class, age, sexual orientation, and identity" (Wiechelt, 2008, p. 974). The etiology and course of substance use problems as well as treatment and prevention needs of

women vary from those of men (Wiechelt, 2008).

Murray-Lane (1995) pointed out that substance misuse by and among women was once considered to be rare and unusual. This, as well as related problems, was more associated with the experience of men. Therefore the male population has been the focus of research and treatment. Over the last 20 years, the number of women addicted to drugs and alcohol has increased dramatically, which has started a shift in the focus of research and treatment. The Office of National Drug Control Policy (2006) stated that the tendency for issues of substance abuse in girls and women to go unnoticed is beginning to change. Murray-Lane's research revealed that until the past decade, the substance abuse field has unfortunately focused research, education, prevention and treatment primarily on men. Recent literature clearly indicated that chemical dependency affects women differently from men in important ways.

Specific differences between women and men. In addition to the literature that indicated that chemical dependency has a unique influence on women, there are extensive statistics that have clearly provided evidence about these differences. To begin, it is shown that in women over 65, three times as many use sedatives and antidepressants than their male counterparts (Murray-Lane, 1995). Heroin addiction is increasing at a faster rate for women than for men and twice as many women as men are admitted to hospital emergency rooms for drug overdose (Murray-Lane). A national survey of drug use among high school seniors found that three times as many female students as males misused diet pills (Murray-Lane).

Similar issues for women were explored by Wiechelt (2008):

A 3-year study sponsored by the National Center on Addiction and Substance Abuse indicated that girls and young women are more vulnerable to abuse and addiction: they get hooked faster and suffer the consequences sooner than boys and young men. Women,

in general, experience physiologic consequences sooner than boys and young men. They appear to get sicker faster and have death rates 50%-100% higher than males. Violence and victimization has been associated with women's substance abuse, including adult experience and domestic violence and rape as well as childhood sexual abuse, physical abuse, or neglect. (p. 973-974)

Social and psychological implications for women. The research of Chudley et al. (2005) suggested that women who misuse substances are often judged more harshly for their behavior than are men precisely because they are the bearers and primary caretakers of their children. The women therefore, not only affect themselves, but the effect of their substance use extends to their unborn and live children. Furthermore, women who use alcohol or other drugs during pregnancy place their unborn children at heightened risk for developmental delays and disabilities as well as physical and neurological deficits (Murray-Lane, 1995). As a result of these pressures, "some view being a woman in itself as a painful and defective burden" (Murray-Lane, p. 94).

Morrison's study revealed that women experience a greater sense of shame and social stigma about their chemical dependence than do men, and suffer, as well, from more intense feelings of self-hatred and mistrust (as cited in Murray-Lane, 1995). Babcock and Connor (1981) claimed that women internalize a greater negative self-image due to their alcoholism, bringing an increased burden of guilt and low self-esteem to treatment.

Furthermore, Fuhlrodt (1990) found that women are more able than men to identify the painful causes of their addiction. As a result, they blame themselves for their disease regardless of their life situations. They are also secretive about their addiction, which creates a vicious cycle.

Sexual abuse. In continuing to describe the unique issues relating to women and their addiction, Covington's (1985) research indicated that more than half of all chemically dependent women are survivors of incest, molestation, and/or sexual assault. According to Murray-Lane (1995), many addicted women are promiscuous, have been sexually assaulted or have engaged in prostitution while under the influence. Others use chemicals to blunt the painful memories of childhood abuse.

One research study conducted by Wiechelt and Sales (2001) examined the relationship between childhood sexual abuse and the difficulty in recovery experienced by some female members of AA. This research study, conducted in an interview style, examined the experiences of 53 alcoholic women in recovery who were members of AA in Pittsburgh, Pennsylvania.

Participants who reported a history of childhood sexual abuse were compared to members who did not report a history of childhood sexual abuse on internalized shame, relapse, and social adjustment in recovery. The ten-page instrument was designed to elicit both qualitative and quantitative data on a broad range of variables. The results of this study found that childhood sexual abuse did not appear to be a contributor to internalized shame in this sample, although shame appeared to have a significant impact on both measures of difficulty in recovery (Wiechelt & Sales, 2001).

Although this study conducted by Wiechelt and Sales (2001) does not report a correlation between childhood sexual assault and increased feelings of shame, it does support the related findings that shame has an impact on difficulty in recovery.

Gender-specific treatment. Because of the profound implications that gender has on addiction, a gender-specific treatment appears to be the natural and intuitive treatment program for women. The research done by Malpede (2005) provided evidence to support this treatment

environment for women. The research revealed that most women felt their experience in a gender-specific treatment environment allowed them to express their feelings freely, whereas they would not have been as comfortable self-disclosing certain shameful experiences and feelings had the group been co-ed. Most of the women who started out in treatment experiencing intense levels of shame, gradually moved to a "sense of safety to self-disclose feelings of shame and their authentic selves, and eventually to a sense of wholeness or healing as a result of the experience" (p. 54).

The core themes in the experience of shame for the women in Malpede's (2005) study included: "worthlessness, isolation, relationship disappointments/losses, and a sense of hopelessness and despair" (p. 36). The core themes related to the experience of self-disclosure included: "resonance, safety/trust, honesty and authenticity" (p. 36). The core themes related to the experience of healing included: "universality, interconnectedness, self-acceptance through the acceptance of others, and hope" (Malpede, 2005, p. 55). Lack of social support, a topic studied widely in relation to stress and health, has been shown to play a role in problem drinking through its direct associations with anxiety, depression and distress. The presence of social support has been found to promote positive coping responses to stress and to improve treatment retention and recovery from alcohol problems (Mulia, Schmidt, Bond, Jacobs & Korcha 2008). These findings correlate with Malpede's (2005) study, which provided a form of social support as evidenced by the interconnectedness and self-acceptance experienced by the group members through the experience of self-disclosure.

The most accessed of all mutual-help groups in the world, which includes self-disclosure as one of the tenets, is the 12-step model of recovery (McGrady & Miller, 1993). The original and most popular of all 12-step programs is known as AA. Due to its low cost and high

availability in most communities, service providers often encourage people to use 12-step programs. The first of the 12 steps that members must embrace in AA states, “We admitted we were powerless over alcohol—and that our lives had become unmanageable” (Alcoholics Anonymous World Services, 1976, p. 59).

Many critics, especially feminists, provide further arguments for a gender-specific approach to recovery as they find this first step to be unhelpful and unhealthy for women who are potentially moving into a healing phase of their lives (Beckman, 1993; Kaskutas, 1996). Others similarly view powerlessness as disempowering to women and assert that admitting powerlessness is not helpful for women in a patriarchal society where they have experienced oppression and powerlessness throughout history (Rhodes & Johnson, 1994).

It has been shown that women members of 12-Step who question the tenets of powerlessness are sometimes shamed, threatened with abandonment, and called resistant (Matheson & McCollum, 2008). These types of reactions toward women defeat the purpose of helping women overcome shame. Instead of feeling empowered, developing a sense of internal power, and using that feeling to set them on a drug-free path, a program with the foundation of powerlessness may contribute to women’s sense of subordinate status, oppression and shame (Matheson & McCollum, 2008).

Additionally, Murray-Lane’s (1995) research supports the notion that chemically dependent women benefit from gender-specific treatment. The basis for these findings lies in the fact that in groups with men, women often take on the role of facilitator and nurturer, and as a result do not deal with their own problems. It has been shown that participation in all-female groups allows women to address issues they might not otherwise discuss, partially due to the roles typically assigned to women by men. Babcock and Connor (1981) believe that a female

therapist should lead an all women group in order for effective role modeling and assertiveness to be provided.

From this information it is easy to see that regardless of whether sexual assault was shown to be a contributor to shame in the above mentioned research study, there are countless other causes to explain the existence of shame in women. Likewise, the factors listed above provide clear evidence for the prevalence of addiction in women as well as the difficulty they face in their recovery.

Summary of Literature

There is much more information pertaining to the topics of DMT in terms of addiction and shame, particularly with women, that I wish to explore. To begin, I would like to more extensively explore shame and the components of its development, separate from addiction. It was not possible to address as many areas of shame and addiction as desired, as a result of the limited research available. Specifically, I would like to know: are there predominant causes for shame that takes form in the general population? Additionally, will determining this help to inform my own research within the field of addictions?

Delving deeper, I would like to discover how DMT could be utilized to address shame in a gender-specific treatment program for women. It is apparent that DMT's ability to connect individuals to their underlying feelings that are being held in the body is one way to address the shame within women. As a dance/movement therapist (in training), I would like to explore the question: how can a dance/movement therapist utilize movement interventions to help women during their recovery from drugs and alcohol?

From the literature reviewed, it seems that women have a proclivity towards internalizing the shame they experience, related to their inability to fulfill the roles both self-imposed and

socially imposed upon them. This causes them to seek out relief through chemicals to alter this state or feeling. Additionally, evidence shows that addiction affects women very differently than men, statistically and through psychological research. As a result, research revealed that women would benefit from gender-specific treatment programs where they were not putting the needs of men above their own and assuming a care-taking role.

The care-taker role some women assume in groups with men, which limits their capacity to heal, is also the role expectation placed upon them, causing them to be judged more harshly when it is not fulfilled and likewise negatively affects their psychological experience (Chudley et al., 2005). It appears as though women cannot escape the negativity on both ends, as either assuming or rejecting the role and responsibilities of a care-taker have been shown to negatively affect a women's treatment experience. This has also been shown to be a cause of shame, which contributes to the cycle of addiction.

Is shame a predominant emotion experienced in women during recovery from addiction? Within my research, I explored this question to determine whether or not this concept in the literature would be true for this specific group of women. Additionally, the overarching question I answered during this study was how is shame seen and expressed in women during the treatment process of addiction? Asking these questions is crucial for understanding women's emotional experience, in order to make appropriate conclusions for treatment goals, both through movement and for addressing the contributing factors to their addiction. Finally, this study answered the question, what are the contributing factors to the women's addiction and shame?

In addition to answering these questions, I addressed the shame women may experience surrounding the social roles imposed upon them, (including victimization through sexual and domestic abuse) which perpetuates the negative cycle of addiction. Lastly, this study addressed

the potential for body based DMT techniques and interventions that address the issues the women presented.

A gender-specific treatment environment for women is suggested in order to eliminate the tendency or obligation women have to care-take. This study also makes me curious about whether it is possible to intentionally create an environment where women can focus on their own needs through the utilization of DMT interventions? Additionally, I am curious how a unique and safe treatment environment for women to address the responsibilities of care-taking and the shame they feel can be created? Likewise, what types of body based interventions can be developed and applied in order to accomplish this goal?

Other questions this study may contribute to for further research are: how can treatment for women address the contributing factors to their shame and their addiction? Beyond the parameters of addiction, what factors cause women to experience shame? Lastly, how can a gender-specific treatment program benefit women?

In the next chapter, the methods used to conduct this study will be presented. This includes the methodological approaches that were utilized to gather the information discussed in this thesis. The participants of the study, the specific procedures used to gather the information needed, as well as the way in which the data was analyzed to determine the themes that arose within this study are described.

Chapter Three: Methods

Methodology

The methodology used in this research is a combination of phenomenological approach and a clinical case study. The phenomenological approach is applied to single cases or to serendipitous or deliberately selected samples (Moustakas, 1994b). This approach is effective at bringing to the fore the experiences and perceptions of individuals from their own perspectives and therefore challenging structural or normative assumptions (Moustakas, 1994b). “The purpose of a phenomenological approach is to illuminate the specific, to identify phenomena through how they are perceived by the actors in a situation. This includes gathering ‘deep’ information and perceptions through inductive, qualitative methods such as interviews, discussions and participant observation and representing it from the perspective of the research participant(s)” (Lester, 1999, p. 1). “The researcher then describes the structure of the experience based on reflection and interpretation of the research participant’s story. The aim is to determine what the experience means for the people who have had the experience. From there general meanings are derived” (Moustakas, 1994b, p. 1).

Phenomenological research methodology is an appropriate approach for the purposes of this study. This was due to the fact that in order to illuminate women’s emotional experience in recovery, I wanted to gather information about the women’s experience while in their addiction as well as during their recovery. My intention was to gather the information from their perspectives in order to identify what issues or themes were revealed during their recovery process. Then I described the women’s experience based on my interpretation of the women’s stories. My description was based on the representation of their experiences, and the coinciding movement observations. The representation of their experiences occurred as they spoke about

their addiction as well as their recovery within the DMT groups I led with the women.

The second methodology used in this research was a clinical case study. This is “a detailed examination of an event (or series of related events) which the analyst believes exhibits (or exhibit) the operation of some identified theoretical principle” (Chaiklin & Chaiklin, 2004). A case study is one of the traditional approaches to research in DMT (Chaiklin & Chaiklin, 2004; Combs, 2005; Weatherby, 2004). A clinical case study was relevant and useful for the type of information I intended to collect through my research. This was due to the fact that this study examined a specific clinical event guided by clinically relevant questions. I examined the clinical event, which were the experiences of these women involved in short-term recovery from substance abuse. Furthermore, the intention of this examination was to answer the clinical question: Is shame a predominant emotion experienced by women during the recovery process from drugs and alcohol?

A clinical case study in combination with a phenomenological approach was the most appropriate methodology for examining the women’s experiences to determine whether shame is experienced. Yet, at the same time, I did not enter this research process with motives to influence the groups in the direction of discussing shame. I kept my perspective open to identifying other phenomena besides shame that may surface for the women and invited the women to present the most salient issues they experienced at their will.

Participants

The study was based at an agency in the Chicago area, which specializes in treating substance abuse. I had worked with some of the women previously in therapeutic capacities within the same agency. The women were various ages, ranging between 20 and 45 and of African American descent. They were approached for participation from an existing therapeutic

group that met daily. The six women selected to participate were only currently undergoing treatment for substance abuse and not mental illness so as to eliminate the variables this additional factor would present. Four out of the six women had previously undergone treatment for substance abuse.

Procedures

The research process began with a verbal invitation by a counselor from the facility to women involved in treatment who did not have a dual diagnosis. The women were informed verbally that their participation was completely voluntary and beyond their regular treatment obligations for the program. Therefore, they were informed that there would be no consequences for declining participation. The first meeting with the women began with the completion of informed consent forms (see Appendices B and C). The informed consent forms were given to the women, read aloud by myself, and explained prior to any of the women signing the forms. Similarly, it was communicated to the women that since the DMT groups would be separate from the current therapy they were receiving; if they chose not to participate, it would not affect their treatment experience. Lastly, they were told that these groups served to help future clinicians treat women like themselves, in recovery for addiction, as well as contribute to the completion of a master's thesis.

Originally, six women signed up to participate in the groups. The original six attended the first two weeks. Then over the next four weeks, the group size decreased. The third week five women participated; the fourth week four women participated. Finally, for the fifth and sixth weeks, the groups were reduced to two women.

I led a total of six DMT groups with the women participants. I held the groups once a week for one hour on Mondays at 9 o'clock in the morning in the women's day room.

I explained to the women participants that I would not disclose any personal information about what they say in the group to others outside of this group and I asked them to do the same. Although due to the fact that I cannot control what they do outside of group, I let them know that I cannot ensure complete confidentiality.

I collected the data by video taping the six DMT groups I led with the women volunteer participants. The groups were recorded by a video camera, set up on tripod on one side of the room. After the completion of each group, I journaled about the groups, including themes that came up and my overall impressions and reflections.

While leading the groups, the inquiry about shame was present in my mind but I did not impose this as a theme on the groups. Instead I derived the themes solely from the information the women brought up. Each group began with deep conscious breathing accompanied with grounding through the feet. The women sat in chairs with their feet placed flat on the floor, simultaneously with their breath, they lifted their arms up along the side of their bodies and reached over their heads as they inhaled. On their exhale, the women lowered their arms down in front of their bodies. They repeated this sequence three times. Following this breath work, the women took turns introducing themselves to the group and checking-in by verbally sharing how they felt. In addition to their verbal check-in, the women shared a movement that also expressed how they felt mentally or physically. I continued to process verbally with the women throughout the group.

During the verbal processing, I periodically asked the women to connect to their bodies and notice what they were feeling and sensing while sharing their experiences. Additionally, I reflected verbally and physically what I observed in the women's movements in correspondence to their verbal disclosures. I used this reflection to increase the women's awareness of the

connection between their mind and body. Furthermore, I made movement interventions by guiding the women to engage in specific expressions through their bodies. Lastly, we ended each group with the same conscious deep breathing; arm lifting and grounding exercises with which we began.

Data Analysis

When I completed the data collection, I immediately began to analyze the data by reviewing my journal entries and the video clips of the groups through content analysis (Moustakas, 1994a). I identified themes that emerged by comparing my journal entries with the video clips. I reviewed and compared the journal entries from each of the six sessions. Next, I reviewed the videos of each session. Reviewing the video clips deepened my understanding of the journal entries by validating and expanding upon the information I had written in my journal. Following this comparison, I listed the themes that surfaced more than once. I then separated and listed the themes that showed up in order of highest to lowest frequency. After I designed these lists, I made connections between the listed themes and combined similar themes under larger, more encompassing headings. Finally, I continued to narrow down the headings until I arrived at the most prominent themes that surfaced with the women.

Once I had determined the themes, I revisited the videos and documented quotes during the moments they expressed explicit references to emotions. These movements became evidence to support the themes that surfaced from the data I had collected. During the video moments when I documented the women's quotes to support the derived themes, I also observed and analyzed the women's bodies and movements as they were making their statements.

I specifically recorded and described in Laban Movement Analysis terms the moments when the women expressed these explicit references to emotions or the themes. Additionally, I

made correlations between movement expressed and the emotional significance using Laban Movement Analysis theory. From this information, I concluded the movement themes for the women.

Once I made the connections between verbal and non-verbal themes, I summarized my analysis. The data analysis was qualitative in nature as it was my interpretation of the women's experience. This allowed me to answer the question, how is shame expressed verbally and non-verbally in women undergoing treatment for addiction? The results are a presentation of those findings in a combination of clinical case study and phenomenological study, as it described the issues and emotions that were expressed in the groups. In the following results chapter, I will present the most salient themes the women presented while processing their experience during their addiction as well as their recovery process. In addition, I will present the movement themes that corresponded with the themes in their lives.

Chapter Four: Results

During the time I led DMT groups with the women, they processed their experience while using as well as their experience during their recovery process. Themes the women presented within the therapeutic process were: circumstances that contributed to their addiction, the shame they experienced as a result of their addiction and goals they had for their lives, which would help them remain sober. When speaking about all three of these issues, the women most often referenced their recurring life struggles regarding relationships, responsibilities and self. In the following section, I will discuss how the themes the women brought up in the therapeutic process, relate to their recurring life struggles. These most prominent themes were circumstances related to relationship, circumstances related to responsibility, circumstances related to self, guilt related to relationships, goals related to relationship and goals related to self. Additionally, I have included my concurrent movement observations within the data. As will be discussed in the following chapter, data revealed that the most salient movement themes for the women were shaping qualities.

Circumstances Related to Relationship

There are three different kinds of relationships in the women's lives that played a role in the circumstances that contributed to their addiction. First, the women's family of origin will be discussed. The romantic relationships in the women's lives will follow. And lastly, the women's relationship as a parent to their children will be included.

Family of origin. The women's family of origin contributed to their low self-esteem and in turn their adult addiction. As the data will show, these women's immediate family relationships were emotionally abusive. As a result, they did not have the time, space, self-esteem, or skills to express their true nature. In time, they lost their connection to their own

intuitive selves. Consequently, the women found a connection to themselves and an ability to express their true self while using. However, this connection they found was not truly authentic as it was only while they were under the influence. The result of the continuous abusive treatment they received from their families caused them to use even more. This abuse ultimately contributed to their addiction and impeded their recovery process. This was illustrated in the data by Krystal's statement: "everything I said, he made me feel bad, so I just stopped speaking up. When I was drinking, that's when my personality would come out."

In addition to the relationship abuse, the women's families also expected them to fulfill multiple roles in order to complete the broken family unit. During the DMT groups, the women spoke about how they did not have the opportunity to attend to their own needs, and eventually they lost the ability to recognize what those needs were. However, using served this purpose. Through using, the women were able to eliminate all aspects of their lives except their own basic desires and immediate needs. Teresa's body movement that accompanied the following statement was evidence of this observation. "I had to fix my little brothers' food, like they were my kids. I was still a little kid too." As she spoke, her torso was advancing forward and enclosing until her upper body folded down and over her legs. Also, while she said, "All my sisters, my mama, they leaned on me, they counted on me," her upper body was sinking down towards her lap with inwardly rounded shoulders, enclosing toward her chest. Regina's statement corroborated evidence of similar family dynamics: "It's like everything that's goin' on, they call me. I'm the fixer, I'm grappling myself, I gotta' get me together." Krystal also expressed distress about unwanted, premature responsibility as she shared: "I was forced into motherhood before my time."

Romantic relationships. The women's romantic relationship dynamics also contributed to their addiction. As adults, the women created abusive romantic relationships that mimicked their formative family dynamics. The fact that the women didn't have healthy romantic relationships caused their lives to become much more challenging to manage on a daily basis. As a result they re-engaged and intensified the initial triggers for their addiction, causing them to further seek self-care, personal freedom, and escape through using.

The initial onset of this cycle began when the women committed to relationships as a way to serve unfulfilled basic needs or to avoid legal or financial difficulties. This was evidenced by Krystal's statement, "I married for the wrong reasons [Because my baby was born with cocaine in her system]. He [my baby's father] would have gotten the baby. This was the worst mistake of my life."

Furthermore, in these women's experiences, their partners constantly blamed and found fault in the women. This was substantiated in the data by Teresa's statement: "He used to make it out like something was wrong, like I was crazy. I would feel like I was crazy. When I was getting high or when I ain't gettin' high, it's the same thing with him."

In these women's experiences, spouses also berated them about mistakes they made, by bringing up examples of the women's negative behavior while using as well as when they were sober, without any chance for forgiveness. As a result, they were forced to relive their pain and shame over and over. This shame perpetuated their negative perceptions of themselves, adding to their overall anguish and caused them to use drugs and alcohol more. This was evidenced in the data by Krystal's statements: "They will find anything to say or do to pick at you to get you mad and make you feel like a bad person." "What he said just made me lay down and cry. I didn't have any strength when I first got here. Only strength was my two little girls. He made me feel

like I was nothing.” As she said this, she brought her arms up to her chest while enclosing in her torso.

Relative to the women’s experience when using, the women’s romantic relationships also involved people who enabled their behavior. Although the women’s partners put them down, they did not support them to change; instead they allowed their negative behaviors to continue without significant repercussions. This experience was represented in the data by Teresa’s statement: “I’m sure if I woulda’ had to pay consequences, I woulda’ stopped doing all that.”

Parental relationships with children. The women’s parenting relationships influenced each woman’s development of an addiction. Although the women married to avoid discomfort, habitually their partners were unable to ease their burdens and reduce their overall responsibilities as a parent for their children. On the contrary, as a result of their choices in partners and fathers for their children, the women gained even more responsibilities and stress in their lives. Oftentimes, this responsibility increased due to the absence of a father for their children. Additionally, although the relationships as partners ended, the men still often sought help from the women to keep their lives together. Regina expressed her feelings of increased pressure due to her children’s father’s lack of involvement and continual need for support.

I’m not fittin’ to let my children’s father be out there like that because I have to answer to my kids...mama why didn’t you help our daddy? You coulda’ helped him...and you don’t want that burden...you don’t want to hear your kids hurt like that. It makes you even madder and hurt that at least one of us is tryin’ to do the right thing, and you can’t help out. Even though I’m trying to get myself together, my mom and dad have my kids, but it’s not like they dad can’t come help. And it makes me angrier that you know what I’m trying to do and you out there and able to help out a li’l bit. Why don’t you take a li’l

burden off my mom and dad sometimes? But I have to think about, I put myself in this situation.

As Regina made this statement, she was advancing forward in her torso when talking about her child's father not coming through. Then she began enclosing in her chest and torso when she shared: "I put myself in this situation."

Regina continued to offer evidence for her experience of an unhealthy parenting relationship as she stated, "It takes a toll on us emotionally. It really do [fathers not taking care of their children] makes me feel angry...like why did I choose this n****? They're finding all kinds of ways to get out of responsibility."

Circumstances Related to Responsibility

In the following, the impact of the women's parental responsibilities on their addiction will be presented.

Parental responsibilities. Due to the types of relationships manifested as adults, the women continued to perpetuate the same responsibilities expected of them as children. Because their responsibilities were neither wanted, nor consciously chosen, the women became overburdened with their responsibilities. This resulted in the women's choice to escape through using. Using allowed them to neglect their children and husbands. This was demonstrated by Krystal's statement, "I had to take care of everybody, but when I started getting high, I left my own children. Became too much to bear. I was takin' care of everybody but my own kids. When I started getting high, I dun' left them." As she made the statement "when I started getting high," she was sinking downward with her head and enclosing slightly in her chest and arm. And when she shared "I dun' left them" she began spreading outward slightly with her arm and chest.

Likewise, Teresa also shared, “I already knew I was the glue, but I had to do what I had to do in my own time, when I’m ready.”

Circumstances Related to Self

In the following, the circumstances related to the women’s inner-selves that contributed to their addiction will be discussed. To begin, the women’s discontent and disconnection from self is presented. Next, the women’s isolation will be explored. Lastly, the way in which the women’s low self-esteem and inability to express their needs contributed to their addiction is illuminated.

Disconnection from self. The women’s disconnection from themselves and inability to recognize their needs influenced their addiction as an adult. As the women continued to process their experiences throughout the DMT sessions, they spoke about a disconnection from themselves. Life had become so much about what they could do for others, that they were neglecting themselves more and more as time went on.

When the women spoke about self, they brought up issues related to being unfulfilled, dissatisfied and disappointed. Although substance abuse did provide them with the increased opportunity to live a life focused on themselves, they craved something more from their lives. They had a strong desire to actualize themselves beyond the moment and become more connected to their true nature. This was illustrated in the data by Krystal’s statement, “when I was drinking, that’s when my personality would come out.” This desire is further illustrated through Krystal’s additional comment: “I used to be more internal, but now I want to be more outspoken. I really didn’t know how to express myself and stuff like that [while suffering from addiction].” She demonstrated this through her body by retreating in her torso while enclosing in her chest.

Isolation. The women isolated themselves from others, causing further loneliness, sorrow and a deepening of their addictive cycle. As a result of wanting to close themselves off from the poor treatment they received from others, the women began to remove and separate themselves from the people in their lives. This separation caused the women to feel isolated, and consequently created a deeper lack of connection to themselves. This lack of connection to themselves and others created a void that needed to be filled. The use of drugs and alcohol filled this void. Consequently, using only perpetuated the women's isolation.

As the women began to use, they became even more closed off from others and refused support. Ultimately they found themselves stuck in this vicious cycle. This was demonstrated in the data by Krystal's statement: "I was drinking all the time. I really didn't want to be bothered with nobody. I was just making myself feel lonely and avoiding stuff." While Krystal expressed this experience, her body was retreating and sinking in the torso while she said, "now I need that support." Additionally she stated, "When people wanted to be bothered with me, I was just like naw', I don' want to, I don' want to. I was just pushin' 'em off and off. But now, I need that support." Regina similarly expressed: "people wanted to be there for me, but I shut them all down."

Inability to express themselves: Low self-esteem. The women in this study suffered from low self-esteem and an inability to express themselves, which contributed to their addiction. Additional issues the women faced within themselves were their lack of boundaries and self-awareness. This lack of self-esteem and self-awareness was evidenced by their inability to communicate or acknowledge their abilities, strengths and skills at the time when the DMT groups first began. This was exemplified when I asked the women to describe a positive quality about themselves. Regina replied: "I can't think of nothing good." The women also lacked

boundaries and the ability to say no, which resulted in allowing people to take advantage of their generosity. This was evidenced in the data by the common complaint from the women during groups that other clients in the facility constantly asked them for favors or material goods. The women felt frustrated because they did not have very much to give but did so anyway. This seemed to stem from the fact that they had low self-worth and undervalued their needs and desires, therefore causing them to concede to others' needs. This was evidenced by the women's disclosures that they were denied basic needs as well as the opportunity to be heard as a child. The women disclosed that most of the time they had to fend for themselves, and learn to live with the poor treatment they were given. As a result, they were conditioned to feel that their needs were not important.

This negative conditioning caused the women to suppress their needs from a young age. As adults, they felt as if the only time they could focus on their needs was while they were using. The suppression of their needs additionally caused the women to lack a self-concept, evidenced by their statements in the groups that they felt disconnected from themselves, as when Teresa said, "I don't know how to make myself happy." The women also possessed poor communication skills resulting in an inability to vocalize their needs and feelings to others. The absence of these skills in their lives was evidenced in the data by Krystal's statement: "I wanna' work on how to say no sometimes cuz' I'm too generous and nice to people." Also, Teresa expressed the steps she was taking to stand up for herself when she stated: "I'm learning how to say yes, no and I changed my mind."

Shame Related to Relationship

When exploring the topic of shame, the women most often brought up issues concerning their relationships with their children. The women experienced tremendous shame and

disappointment in themselves as a result of not living up to the expectations of a parent for their families. In the following, the shame the women experienced that relates to their parental relationships will be explored.

Parental relationships with children. The women's relationships with their children caused them to feel tremendous shame. During the time the women were using, they shared that they overtly neglected their children and family. When reflecting back on their behavior, the women recognized that as they continued to do this, their family felt more and more rejected and disregarded. As they failed to give them attention and care, their family's needs became even greater. Realizing this during their recovery process, the women expressed shame as a result of choosing to escape their responsibilities and not acting as they felt a parent should. While suffering from their addiction, the women failed to consider how their children would be affected by their absence. The women were also unaware of the seriousness of their behavior and how their disregard for others while using affected their relationships or themselves while using. When processing this during their recovery, the women felt shame due to the fact that they let things go too far and now that they were in treatment, they again had to be away from their family. They felt like they were denying themselves the joy they could have experienced. This sentiment was illuminated in the data by Patty's statement:

I had made up in my mind this sick thing that if I couldn't be a solution, then I wouldn't be a hindrance and I would stay away. But then I realized that me staying away and running away from my problems was more than a notion of mental abuse towards my children because I'm not acknowledging them and how they feel.

Krystal also shared a common experience by expressing: "I be feelin' bad that I'm in here [treatment] and I can't go get my babies." She also stated that while she was using, "I was doin'

what I wanted to do whenever I wanted to do it. I gotta' listen sometimes." Krystal expressed this through her body as she began enclosing inward through her chest.

Teresa disclosed her disregard for her children's needs while using, by sharing: "They [my kids] just wanted me to leave from out that environment and come home. But I would never do it. I say I comin' when I get ready, don't call here no more." She admitted that she failed to acknowledge what her partner and children needed from her when she was using. While she stated this, her body was enclosing through her chest.

When I asked the women if it feels like a burden to have to take care of and be responsible for their children, Regina responded: "I feel like it's something I have to do [take care of my children] but I wasn't doin' it." I then asked the women: how does that make you feel? Regina responded: "It hurts. It hurts real bad. I say to myself how could you be so stupid?" She expressed the disappointment she felt in herself by sinking in her head and chest, and enclosing in her chest. "I can't control how someone else takes care of my kids. That's the price I pay for doin' what I was doin' on the streets." Teresa stated: "Now I'm stuck here and can't do it." While she stated this shame and remorse she was hunching over, sinking downward in her torso. Teresa continued to share: "I was bein' just like them [my family who used]. I'm disappointed in myself. I had become something I told myself I would never be. I hate that."

When the women were engaged in their addiction, they were ashamed of the person they were and didn't want to continue to be that person for fear of how their family would be affected. This was evidenced in the data by Teresa's statement: "My daughter is pregnant now. I can't be havin' a baby come in and say that's my grandma, what's wrong with her?"

Goals Related to Relationship

When the women discussed goals for themselves, they most often brought up issues related to their relationships. To begin, a discussion of the goals, which were related to their parental roles will be presented. The women's goals regarding their relationship to others will follow.

Parental relationships. When planning to create a better life for themselves, the women developed goals related to improving their relationships as a parent. Many of these goals were directly related to the shame they experienced as a result of their behavior while using. Many of the women's goals addressed their desire to be a better parent and role model for their children and a more stable part of their children's lives. The women also realized that their relationships with their families gave them the strength and motivation to stay sober and make better choices in their lives. This was demonstrated by Teresa's statement: "I want to be a better mom for my children, sober, responsible." Krystal additionally shared her need for her family's support by stating: "Ya'll is my hope and stuff to keep me movin', if ya'll stop now, I'm just gonna' stop too."

Relationships to others. Toward the end of the groups, the women also expressed many goals related to improving their relationships with others, including family and friends. They realized that in order to do this they needed to be able to communicate what they needed. Also, they expressed a strong need to stand up for themselves. This was evidenced in the data by the women's comments that they wanted to learn how to say no. They decided they could accomplish this by becoming more assertive and preventing other people from bringing down their spirits. Similarly, they also wanted to avoid overextending themselves and expecting themselves to help everyone. They processed that they could achieve these goals by setting

boundaries when in relationship with others. Regina reflected this in the data when she shared “I’m gonna’ try and make [positive] choices for myself whether they [friends and family] like it or not.” Krystal communicated her desire to stand up for herself as she stated: “I’m not gonna’ let them steal my little spirit, my little joy. That’s why sometimes I don’t even call them anymore.”

Conversely, the women realized another helpful goal was to allow themselves to open up to others. They recognized it was important to allow others into their lives in order to build a community of support and strength. This realization was revealed in the data when the women shared that they felt disconnected and unhappy when they isolated themselves while using. They also shared that the negative effects of this isolation caused them to sink further into their addiction. Therefore, opening up and receiving support from others could help decrease the women’s risk of relapse. Additionally, they recognized that choosing wisely to prevent negative people or situations from entering into their lives would be a crucial element for reducing relapse. Krystal shared her attempts at inviting others into her life by expressing: “I’ve been opening up to others, it makes my days go by a little bit faster. Smilin’ and makin’ people laugh makes me have a lil’ more patience for these people up in here.” Krystal slowly spread outward through her torso while she shared how she began to open up to others and have more patience.

Goals Related to Self

When processing how they wanted to improve their lives, the women expressed many self-focused goals. First of all, the women had a desire to understand the external contributions to their addiction. Additionally, the women possessed a desire to strengthen themselves. In order to achieve this strength, the women expressed a desire to stay positive, improve their self-reliance and take initiative in their lives.

Recognizing needs and taking steps to remain sober. The women had a strong desire to recognize their needs in order to take the appropriate steps to lead a sober life. One of the steps the women wanted to take toward recognizing their needs involved finding healthy ways to spend time focused on themselves. This time with themselves would help develop a stronger self-concept and increase their likelihood of living healthy sober lives. Krystal shared how she could cope with the challenges of remaining sober by stating: “I can stay focused on myself, not worrying about other people.”

Another step toward the goal of staying sober was making thoughtful plans for how they could avoid situations and interactions with people who may lead them off their path of recovery. Teresa expressed the action she took in order to eliminate temptations to use:

One of the reasons I chose to come to treatment now is because my sister will have moved by the time I get out and I’m not planning to find out where she’s living. That way the temptation of going there to use will be gone.

Understanding contributions to addiction. An additional goal the women established for themselves while in recovery was to discover why they began using through self-reflection and examination of their lives. During their time in treatment they experienced a shift of awareness and began to realize that there was more to why they started using than just having fun.

The women began to look closer at their lives, and reflect upon their past behavior and relationships to learn more about themselves. This desire to learn the root cause of their addiction was evidenced in the data by Teresa’s statement: “I wanna’ figure out why I started using in the first place.” Through this reflection, the women began to become more aware of how their romantic relationships had become negative influences in their lives. They realized that these

relationships were unhealthy as they caused them to become focused on their partner's lives and lose focus on themselves.

Regina's disclosures evidenced her realization that her relationship had a negative effect on her life as she conveyed clearly how marrying for the comfort of monetary stability caused her to feel miserable and unfulfilled. She continued to share that her feelings of dissatisfaction motivated her to seek out drugs as a means to improve her quality of life. Krystal also expressed the realization that her partner had a negative impact on her by stating, "What he said just made me lay down and cry. I didn't have any strength when I first got here. My only strength was my two little girls. He made me feel like I was nothing." This was expressed through Krystal's body as she brought her arms up to her chest while enclosing in her torso. She also began sinking down towards her chair in her upper body.

Strengthening self.

Self-Assertion. The women expressed many goals related to strengthening their sense of self. One of the ways they discovered they could strengthen themselves was by learning how to assert themselves. They were working towards identifying the aspects of themselves that they had become disconnected from while suffering from their addiction and dealing with overbearing responsibilities and relationships. Additionally, the women were reconnecting to the positive parts of themselves. Krystal demonstrated how she was making positive shifts and asserting herself within her relationship by sharing: "I say think positive and leave the negative and the past in the past because he [her partner] be bringin' up stuff, sayin' you used to do this, you used to do this and boy that's in the past. Leave that there. This is a new lova', a new day, if you can't follow me where I'm goin', to the next step, then I'm gonna' leave you back there."

In building upon their personal strength, the women had developed an increased desire to express that to the world. Krystal revealed the steps she was taking toward increased self-expression as she stated: “I used to be more internal, but now I want to be more outspoken. I really didn’t know how to express myself and stuff like that [when suffering from my addiction] but now I’m learnin’, I’m gonna’ be outspoken, I’m gonna’ make them hear me.” While she shared this new awareness within herself, she became more relaxed in her upper body by opening up, rising and spreading outward through her torso.

Taking initiative. The women had a strong desire to take more initiative in their lives in order to help prevent relapse. They wanted to begin to rely on themselves more as opposed to others. In continuing to develop this empowerment, they wanted to take more responsibility for their actions, take initiative to ask for help as well as receive support from others.

This ability to take more responsibility was evidenced in the data by Regina’s statement: “As a mother I have to. It’s not a choice [to take care of my children] it’s something I have to do.” Teresa began to take responsibility for her decisions and actions as she stated: “when we had the opportunity to do it, we wasn’t doin’ it then.” She expressed this in her body by leaning forward quickly; retreating and advancing in her torso, then lifting back up by spreading and rising in her upper body. Regina also recognized the consequences of her behavior as she shared: “I can’t control how someone else takes care of my kids. That’s the price I pay for doin’ what I was doin’ on the streets.” The women acknowledged that they needed to commit to a healthier way of life and make better choices for themselves in order to change the course of their lives. This was evidenced in the data by Krystal’s comment that “In order to be the best mother I can be, I need to be in here [in treatment].”

Improving self-reliance. Toward the end of the dance/movement therapy groups I led with the women, they realized that self-reliance and connection to their inner spirit and strength was necessary to help cope with their struggles and remain sober. This was revealed in the data by the women's disclosures that they felt stronger within themselves since entering treatment. They shared that this newfound strength was a result of taking time to focus on their needs and increase their self-awareness. From this new understanding and increased connection to themselves, the women realized the importance of continuing to empower themselves in order to stay sober. Furthermore, they recognized that they could use movement exercises we practiced during our groups, such as grounding through their feet and conscious deep breathing to accomplish a stronger connection to self.

In addition to the grounding and breathing techniques, they acknowledged that they could use the reflection tool of taking time to think about their experiences in order to connect back to self. The women realized that setting aside time to reflect on their situation and experiences would help them gain more knowledge and deeper understanding of themselves and what they need in their lives. Another benefit of this practice would be an increase in their ability to set boundaries for themselves and stay positive and focused regardless of what people try to say and do to make them feel badly. Additionally, these reflection exercises would support their sense of self by taking time to do what makes them feel good, besides using drugs and alcohol.

The new realizations and stronger connections to themselves the women made were corroborated in the data by Teresa's statement: "If I was still in my addiction, I would've sat there and felt sorry about what I did. But now I got more feelings about myself, so I don't let that stuff get to me anymore by maintaining a joyful spirit within myself." Krystal's understanding of

herself was also demonstrated as she shared: “I used to be more internal, but now I want to be more outspoken.”

In the following discussion chapter, I will address the recurring life challenges and prominent themes the women presented during these DMT groups. This will include a discussion of the women’s shame and the phenomena behind the blame they place on themselves for their addiction. Additionally, I will explore the specific contributing factors to the women’s addiction and shame. I will discuss the psychological implications of the shaping qualities that were revealed and potential movement interventions that could be applied clinically. Lastly, I will address issues surrounding relapse prevention and what clinicians might do to help women recognize the contributing factors to their addiction, resolve their shame and strengthen their connection to themselves.

Chapter Five: Discussion

Throughout this study I asked the question, how is shame seen and expressed in women during the treatment process of addiction? The data supported that shame was in fact a primary emotion during the women's recovery from drugs and alcohol. It also revealed that the shame the women experienced was greatly related to the relationships and responsibilities they had had in their lives.

The findings of this thesis supported the existing research that women internalize a negative self-image due to their alcoholism, which causes them to experience an increased burden of shame and low self-esteem during their treatment (Babcock and Connor, 1981). Themes of shame as well as the women's need to increase their self-esteem surfaced within this study. This research also supported that of Fuhlrodt (1990) who found, "Women identify the painful causes of their addiction. In addition, they blame themselves for their disease regardless of their life situations" (p. 23). The women in this study did not see the causes of their addiction as outside of themselves. They consistently found fault within as evidenced by the amount of shame they experienced as a result of relationships.

In addition to expressing the emotion of shame, the women brought up issues related to the circumstances that led to their addiction and goals they had for themselves in treatment. As illustrated in the previous chapter, the issues that the women expressed were related to their relationships, their responsibilities, and self. Although the women discussed issues that contributed to their addiction, they didn't explicitly blame their relationships or initially see the people in their lives as the circumstances that contributed to their addiction. On the contrary, the majority of focus the women placed on changing themselves within their therapeutic goals demonstrated that they placed blame on themselves. Therefore, these findings additionally

support the existing data that the women “blame themselves for their disease regardless of their life situations” (Fuhlrodt, 1990, p. 23).

The data showed a connection between the women’s issues and shame. This shame was developed as a young child, resulting from poor treatment they received from their family while growing up. The poor treatment caused the women to develop low self-esteem therefore causing them to internalize the negative behavior they demonstrated as an adult. This prevented the women from separating themselves from their negative behavior. They internalized their behavior and perceived themselves as bad people for the mistakes they made. One example of this internalization of behavior within the data was when Regina expressed how she felt stupid for leaving her children while using.

The women’s shame was perpetually reinforced during their adulthood through their romantic relationships. The presence of the women’s unhealthy relationships was revealed in the data when Krystal disclosed how her partner’s poor treatment made her want to lose hope, “lay down and cry.” The goals the women established in treatment were heavily based around improving themselves as opposed to changing their relationships. This seems to be a result of perceiving themselves as inherently bad people. Overall the shame the women experienced as children, and continued to experience as an adult, affected their addiction.

Using had become a way for them to do what they wanted in their lives, and become who they wanted to be if only for the time that they were under the influence. It gave them an elusive feeling of freedom from their painful lives, but ultimately only caused them to become more trapped in their shame and addiction. They were acting from a place of lack and deprivation that was developed early in life. Making unhealthy choices had become a conditioned response for

the women. This was demonstrated in the data by the women's statements during the initial groups that they did not know why they were using.

Shame: Blaming Self for Addiction

Initially as the women talked about their experiences while suffering from their addiction, they discussed their relationships, responsibilities, and connections to self. When they examined these experiences more deeply, they clearly expressed shame resulting from the relationships they had in their lives as well as goals that related to their relationships and themselves. The shame the women expressed predominantly stemmed from leaving their responsibilities when they were a parent. The abusive treatment from their relationships seemed to be the greatest contributing cause of their addiction. Regardless, the women felt their addiction was the result of their own personal inadequacies.

As the groups progressed, the women were eventually able to acknowledge that their relationships and responsibilities had contributed to their addiction cycle. Although overall, the women continued to place most of the fault and responsibility for their addiction on themselves. They most commonly internalized the effects of their addiction as evidenced by the shame they experienced related to their relationships. One example of this within the data was when Regina shared that she put herself "in this situation [being in treatment and away from her family]."

This result may have been influenced by the fact that the current treatment was focused on recognizing one's issues and moving forward within a Cognitive Behavioral Therapy (CBT) approach of altering one's thoughts in order to change one's behavior. CBT focuses on the effects of the patient's substance use and immediate skills they can learn to prevent using in the future. Preventative measures include finding alternatives to using as well as identifying triggers to their using (National Institute of Drug Abuse, 2007). This approach to treatment does not

address the psychological or behavioral problems that underlie the addiction. Therefore, long-term, in-depth treatment is necessary to address these issues and establish a commitment to a lifetime of sobriety (Rose, 1995).

Benefits and limitations of focusing on self for recovery. Toward the end of our DMT groups together, the women began to identify how they could improve themselves, rather than change the external factors in their lives. This was evidenced by the large number of personal goals they established for themselves. Again, this focus on self placed the responsibility on themselves instead of circumstances in their lives that negatively impacted their self-esteem. Although the women were moving in the right direction by focusing on themselves, additionally uncovering the deeper psychological problems that underlie their addiction and changing the external influences in their lives may help maintain long lasting sobriety.

Benefits. A focus on self, which includes improving their connection to self, empowerment, self-advocacy and identifying triggers in order to modify behavior may help women rebuild their self-esteem and control their urge to use. Increasing one's self-esteem and offering urge control techniques may reduce the chances that one will use, internalize their negative behavior and feel shame. Therefore, a focus on improving the women's connection to self may be an invaluable aspect of any recovery model. Furthermore, as Articles (2010) believes high self-esteem combats shame, a focus on increasing their self-esteem could also help the women avoid overwhelming feelings of shame, which could therefore reduce their risk of using (Dearing et al., 2005) stay strong and resilient in the face of stress and challenges.

Increasing women's strength and confidence may increase their ability to take more initiative in their lives. It is important for these women to learn that they deserve to be heard and also feel confident enough to take this initiative. Gaining strength and resilience may increase the

women's ability to stand their ground, resist temptation and take positive steps to maintain their sobriety.

Limitations. The treatment facility used a Cognitive Behavioral Therapy approach. CBT encourages clients to alter their thought process and belief systems in order for those changes to be reflected in their behavior. This approach may not have been in the best interest of the women due to the fact that they are already prone to blaming themselves. This approach may reinforce that their flaws are at the root of their addiction. The treatment model, which places an emphasis on unlearning old behavior and replacing it with new more adaptive behavior, in combination with the women's tendency to blame themselves may have influenced their goals to become self-focused.

It could be problematic to focus solely on altering one's self in order to change one's behavior. Within this short-term, CBT treatment, the focus was on immediate personal concerns such as isolation, abstinence and relapse. Although research has shown that in order to maintain long-term sobriety, identifying the deeper psychological and behavioral issues is necessary as well.

Furthermore, professionals within the field of DMT agree that the mind/body is connected. This concept includes the belief that what occurs in the mind affects the body and what occurs in the body affects the mind. This concept can be directly translated to the idea that one's inner world affects their outer and vice versa. Therefore, approaching women in a holistic manner by addressing both internal and external factors in their life may be necessary to create more long-lasting internal and external changes. Considering the women's inclination to self-blame, deepening their understanding of how their environmental and relational factors

contributed to their addiction, may reduce their tendency to blame themselves and experience debilitating shame.

Contributing Factors to the Women's Shame and Addiction

Effects of the women's familial relationships. The women's familial relationships as children had a negative impact on their lives, contributing to their shame and addiction. As a result of their family members' needs being imposed upon them, the women did not have the ability to experience their childhood fully.

The need for the women to experience freedom and escape their responsibilities may have been the result of three factors. First of all, they were denied this freedom, which is a natural part of psychological development, while they were growing up. This was evidenced by the fact that they felt burdened by overwhelming responsibilities as a child. Secondly, a large amount of responsibility was primarily placed upon them as a parent. This was evidenced through the women's disclosures that their partners were not supportive as caretakers. And lastly, the abuse and neglect the women experienced as a child caused them to develop low self-esteem. As research has shown that low-self esteem causes one to view themselves as a bad person due to mistakes they made, the development of low self-esteem caused the women to become more susceptible to internalizing their negative behavior while using. Once the women internalized their negative behavior, these feelings caused them to experience immense shame. The overwhelming shame they felt only increased their urge to escape through using. The women's shame fed their addiction and their addiction fed their shame ultimately creating a vicious cycle in which the women became stuck.

Effects of the women's romantic relationships. As adults, the women found themselves in abusive romantic relationships that were an extension of the abuse they received as a child.

Choosing partners who were not emotionally, mentally or physically supportive caused the lives of the women to become much more difficult to manage and increased their need to escape the challenges they faced. The dissatisfaction in choice of partners was evidenced in the data by Teresa's comment that marrying her husband was the worst mistake of her life.

Despite the men's many shortcomings, the women became bonded and attached to them through the experience of having children. This was evidenced in the data by Krystal's statement that she married her husband because her baby was born with cocaine in her system and would have been taken away otherwise.

The women's burdens were increased when they began using to escape the unhealthy patterns in their lives. When the women were not able to take care of themselves and their children, they could not rely on their partners to pick up the slack and fulfill these responsibilities. In fact the men would often avoid all connection to family responsibilities, and in some cases require the women to take care of their partners as well as the children. This was evidenced in the data when Regina expressed her frustration about the inability of her children's father to take care of their children. In a slightly different scenario, some of the women also chose men who did not fulfill them emotionally but could provide a home and monetary support. Ultimately, this left the women without an emotional connection, and therefore with a longing for something more to complete their lives. Consequently, the women then resorted to using in order to fill this void.

Choice of partners. Many of the women did not choose supportive partners in their lives. The women engaged in patterns of choosing partners who perpetuated the abuse they received; or in an attempt to compensate for the basic needs they were denied as children. The deprivation

and abuse they experienced while growing up, set them up for continued disappointment and dissatisfaction in their lives.

Developmental research on children has shown that if children's needs were met during their developing years, they could more clearly identify their own needs. Additionally, they would be more equipped to make more informed choices later on in their lives to better serve these needs. Therefore, if the women in this study had their basic needs met as a child, they may have been able to recognize their own needs more clearly. Additionally, if their needs had been met emotionally, they might not have gone out in the world with an unhealthy void to fill. Ultimately, if they had received this positive support, they may have made healthier choices for partners in their lives.

What Clinicians Can Do: Helping Women Recognize Contributing Factors to Their Addiction and Take Initiative

Toward the end of our DMT groups together, through the guidance of the counseling process, the women began to recognize that their past familial relationships had an effect on their choices in life. Although they began to realize that their relationships contributed, they did not fully comprehend how their past interactions and relationships had effected them.

As discussed earlier, awareness of the effect their past experience had on their addiction may be important for the women in order to change the patterns in their life and prevent relapse in the future. Based on the social learning theory of CBT, bringing awareness to how women's relationships affect their lives is something we as clinicians could focus on within the recovery process. Illuminating these influences could lay the groundwork for the women to learn new ways in which to engage in relationships and begin to increase the women's ability to make more fulfilling choices in their partners and social support systems.

Supporting women to make better decisions in romantic relationships. A helpful step for altering women's unhealthy relationship patterns may be to improve their ability to recognize the difference between positive and negative relationships. In addition to relationship education, increasing women's ability to set boundaries may increase the likelihood that they will stand up for themselves. These components may help the women make positive choices and growth in the area of relationships.

A step toward helping women recognize the difference between positive and negative relationships could be to incorporate healthy relationship education into treatment models for women recovering from addiction. As is commonly understood in clinical addictions work, it is helpful to offer clients opportunities to relearn healthy behavior. Therefore, it may also prove valuable for women recovering from addiction to be educated about the early signs of domestic violence. This education should include the effects of unhealthy and abusive relationships on the women and their children with the intention of interrupting this pattern.

It could be helpful to hold activities and groups focused on making positive choices in the area of relationships and partners with the goal of helping the women identify the consequences of their choices. Additionally, it may prove beneficial for the clients to be fully engaged in these groups through interactive role-plays. As a standard CBT approach to addiction, the learning strategy of modeling and role-plays could be adapted for use in relationship education with women. Role-plays could be incorporated through the clinician's modeling of how to assert oneself and make positive choices in relationships. The women could then practice responding and behaving in these new and unfamiliar ways by practicing the strategies. Engaging the women holistically through their mind and body would be a powerful way to encourage full comprehension of the exercises for more long lasting effects.

Supporting immediate family and parental relationships. This research uncovered the women's need for support from their families. Without positive support from their families, they were more likely to lose hope and strength. Their statements that their family's support was what gives them strength to stay in treatment evidenced the women's need for support and encouragement during recovery. Lack of support and connection to their families may therefore increase the risk of relapse for the women.

Furthermore, within treatment for addiction, incorporating a program that serves to maintain and strengthen the communication and connection between the women and their families may be helpful for maintaining long-term sobriety. An open line of communication and positive connection between the women and their families will enable the women to receive support during the time they are in treatment. The family members will also be able to receive support from the women. This mutual support could serve to strengthen the family's connection to one another. As is commonly understood within family counseling, an improved connection may lead to healthier family systems. A healthier family system may then contribute to increased stability and strength to help the women remain on their path toward recovery.

Parenting: Improving coping skills and self-esteem. Based on the social learning theory of CBT, the women in this study learned mal-adaptive coping skills from the modeling of their parents. Many of the women had parents who were also using and chose to avoid their responsibilities. Escaping their responsibilities and placing the burden on their children was the form of coping with daily stress and challenges that was modeled for the women. Similarly, the women adopted this escape as the preferred form of coping in their own lives.

Through this study it became clear that the women recovering from addiction could benefit from guidance, tools and support to address many areas of relationships, parenting, and

self-strength in their lives. Therefore, parenting classes for the women may be a vital and necessary aspect of recovery in order to improve the women's parental abilities. Through these classes the women could learn healthy forms of nurturing and guidance to offer their children. This guidance could encourage the development of healthy coping skills and self-esteem in the children. Building self-esteem and offering positive support could help to decrease the likelihood that the women will pass on maladaptive coping skills to their children. Likewise, it could increase their children's ability to make positive life choices, including choices in romantic partners. This positive support and nurturance may encourage the development of healthier, more competent, well-adapted children and help to break the cycle of shame and addiction in the next generation.

Supporting overall health and wellbeing through long-term counseling. Women who are in recovery could benefit from follow up care and counseling services provided by treatment facilities for drugs and alcohol. This would help them fully explore their past experiences as well as pathologies or trauma with which they are dealing. As discussed previously, if these deeper psychological and behavioral issues that underlie their addiction are not addressed and treated, the women may be much more likely to relapse, go back onto the streets and cause the cycle of addiction and shame to repeat itself.

AA is commonly used as a form of long-term follow-up treatment. AA offers an arena to self-disclose and experience universality, although it does not offer in-depth personalized and professional attention. Long-term individual therapy would therefore be more helpful to offer the individual attention necessary to address the deeper psychological and behavioral issues that underlie their addiction.

As discussed in the previous chapter, the women began to understand the root causes of their addiction during their thirty days of treatment. Within this short-term treatment, they only began to scratch the surface of identifying the external and relational factors that contributed to their addiction. They needed much more than thirty days to work on these deep-rooted issues. As evidenced in the data, the women expressed a desire to explore their past experiences and identify the true causes of their addiction. Thus it could be beneficial for the treatment facility to employ follow up programs where the women could transition after they completed their initial treatment.

Resolving shame. As the data clearly presented, shame was a predominant emotion experienced by the women in this study. Therefore, a focus on resolving shame and helping women understand that they are not inherently bad people may be a critical goal for women in recovery. Reducing shame could help them move forward positively and make healthier choices in their lives.

The women have endured a lot of grief, pain and shame as a result of their addictions. The shame stemmed from reactions from their families as well as self-imposed shame for their behavior while using. Helping the women more profoundly understand how the people in their lives and life's circumstances contributed to their addiction could be one of these steps toward making healthier choices in their lives and resolving their shame. Additionally, understanding external contributing factors may help prevent the women from internalizing all of the mistakes they made while suffering from their addiction.

Clinical Implications

Psychological implications of the movement observations. The expression of the women's experiences and emotions were also conveyed through their bodies. I recorded the

instances when they expressed issues surrounding the main recurring themes of relationships, shame and goals in their lives. The data revealed that the most salient movement themes were shaping qualities during the times when they expressed issues surrounding these recurring challenges. In the following, the psychological implications that are associated with each specific shaping quality that was expressed will be discussed.

The shaping quality of advancing through their torsos was expressed in the women's bodies when conveying disappointment, hurt, pain, frustration or injustice they experienced as a result of another person's actions. One example of this was when Teresa shared the stifling amount of responsibility placed on her as a child. Overall, this shaping quality was expressed when the women recognized a sense of wrongdoing inflicted upon them by others.

When they retreated in their torsos they were admitting the truth and reality of their experience, revealing their vulnerability, perceived weakness, flaws or when they needed help. One example of this was when Krystal admitted that during her addiction, she didn't know how to express herself.

Rising and spreading were most commonly expressed simultaneously. When rising and spreading through their torsos the women most often expressed what they wanted, what they needed, or a decision they had made. Additionally, rising and spreading were expressed when they were learning, taking action, growing and making positive changes in their life. These shaping qualities were demonstrated when Krystal expressed that she was learning how to speak her mind and stand up for herself. Overall, the shaping qualities of rising and spreading were expressed when they were asserting themselves, and being an advocate for themselves in their lives.

Sinking was the most common shaping quality the women expressed when

communicating the stress and weight of responsibility that was placed upon them. Additionally, sinking was the shaping quality expressed during intense emotions such as hurt, pain, shame, and disappointment in themselves while they were using. Regina expressed these movements when she shared the shame she felt for not taking care of her children while engaged in her addiction.

Lastly, the women used the shaping quality of enclosing through their torsos when they expressed shame, disappointment, frustration, hurt or pain they felt when they were using. This was demonstrated within the data when Teresa enclosed in her chest as she shared that she left her children when she started using.

Implications for DMT.

Clinical benefits of the movement observations. As clinicians and specifically as dance/movement therapists, we can use these movement observations to inform our work with women undergoing treatment for addictions. As the field of DMT agrees, the mind and body are connected. Based on this concept of the mind/body connection, clinicians can use the knowledge that certain shaping qualities correlate with particular emotions and experiences to help the women make positive shifts in their lives.

One way this could be done is to help women who may be stuck and perseverating in the shame and pain they experienced while suffering from their addiction. This research revealed that the accompanying shape qualities while expressing the emotion of shame were sinking and enclosing. Therefore, if the women were predominantly displaying these shaping qualities or emotions, it may be beneficial to help shift them out of these shaping qualities and therefore away from these emotions. Helping shift the women out of sinking and enclosing could be done by accessing the opposite shaping qualities of rising and spreading.

The data revealed that the shaping qualities of rising and spreading were associated with

the times when the women asserted themselves and made positive growth in their lives.

Therefore, helping the women access these shape qualities may have the ability to bring them into a more positive state of mind. Furthermore, accessing their rising and spreading shaping qualities could shift their emotional state into a positive action inducing state, and encourage self-advocacy and self-efficacy.

Using DMT and clinical practices to improve connection to self. Helping women strengthen their connection to themselves could be done by offering tools and exercises they could refer to when they were feeling highly stressed or emotionally compromised. Teaching clients skills they can use long after treatment is a common approach used within clinical addictions work and a CBT approach, to improve their ability to remain sober. These tools could involve a connection to their body and their breath through body scans and conscious deep breathing. The body connection exercises may additionally improve the women's overall awareness of their emotional and bodily states, offering the women coping skills to handle challenges in their lives. With increased awareness, the women could begin to identify moments when they feel emotionally or mentally triggered. Once they identify these triggers, they could then utilize the movement and body exercises they learned in order to cope with their experiences in a healthy manner. Through the diligent practice of these coping skills, the women could begin to alleviate some stress in their lives, helping to reduce the desire to escape through using.

A focus on increasing self-empowerment and self-efficacy within treatment is another approach that may improve the coping skills of women. As evidenced in the data, the women expressed a need to learn how to stand up for themselves and say no. Learning how to stand up for themselves could help the women set boundaries and make positive choices in their lives.

Empowering women to set boundaries may also help women to begin to eliminate people in their lives who contribute to their stress and shame.

Specific DMT interventions to address shame for women in recovery. Increasing women's ability to connect to their bodies through breathing exercises, body awareness and grounding exercises would be one approach that may help address shame within their recovery process. Increasing women's opportunities for self-expression through movement may offer a valuable opportunity for improving awareness of self, self-assertion and self-esteem. In turn these practices may contribute to increased feelings of empowerment and strength. Additionally, as research has shown, an increase in self-esteem may decrease the likelihood of experiencing shame.

Specifically, it was evidenced in the data that when the women accessed advancing, rising and spreading shaping qualities they were asserting and expressing positive aspects about themselves or how they felt about a situation or experience. Encouraging the women to draw on times when they feel positive and hopeful may therefore influence them to naturally access these shaping qualities within themselves.

The data also revealed that self-assertion was a goal the women had for themselves during their recovery. Encouraging the women express themselves through spreading, advancing and rising may in turn activate these parts of themselves helping them to feel more connected to these positive qualities and abilities they possess. Strengthening this connection over time may contribute to their ability to assert how they feel about their own accomplishments as well as many situations they experience throughout their lives. Through the on-going exercise of asserting themselves, the women may begin to gain more control over their lives in order to remain on the path toward recovery.

A specific way clinicians could help women access spreading, rising and advancing would be to take turns expressing a time when they stood up for themselves. This would offer another variation of role-playing as discussed earlier. The clinician could then assist the women to fully embody these movements and help them modulate into different levels of advancing, rising and spreading. Additionally, the clinician could ask the women to express a situation when they felt wronged. After this exercise, the women could process the emotions that were associated with their experience.

As mentioned previously, it is understood in the DMT field that the mind and body are connected. Additionally, it is understood that connecting the mind and body helps an individual achieve a deeper awareness of their whole self. Through the practice of connecting what they expressed in their body with their mental or emotional experience, the women could gain a deeper awareness and connection to themselves. Consistently applying these reflection tools could lead to the women gaining a clearer understanding and insight into how their experiences impacted them either positively or negatively. Over time, this increased understanding could help the women recognize their needs. The steady practice of identifying how their relationships or experiences have affected them, paired with the embodiment of the assertion exercises over the course of long-term therapy, may offer the women coping skills to handle relationships issues in their lives. Possessing these new coping skills may increase the women's ability to make healthy choices for themselves. An increase in healthy choices may therefore result in increased control over the potential contributing factors to their addiction.

Another layer of this exercise would be to verbally process what the women would change about the situation if the experiences they presented were negative. After a group discussion and feedback, the women could have an opportunity to express their movement once

again to the group. By expressing themselves through movement and verbalization, they would have the valuable opportunity to be heard, supported and validated by the group and the clinician. Additionally, this exercise could strengthen their mind/body connection in effect strengthening their connection to their whole being. Finally, they would also have the opportunity to re-experience a situation from their past and alter it from negative to positive.

If the women are not used to expressing themselves and their feelings, these exercises may also be a powerful way for them to increase their likelihood to take emotional risks within the therapeutic setting and move out of their comfort zone. Furthermore, continual risk taking could allow the women to experience and access new parts of themselves. Discovering new and positive aspects and abilities within themselves could over time create a stronger sense of self and relate to a change the women's self-esteem. The risk taking would be possible both through taking action within their movement and through verbal expression, and is a common goal and benefit of role-playing within CBT. Similar to what was previously discussed, the women may be motivated to use these risk-taking tools to take action in their lives and eliminate some of the negativity that exists. Furthermore, this exercise could ultimately address the goal the women had of improving self-reliance and taking initiative.

In addition to the interventions discussed above, another avenue, which may help women access the shaping qualities of rising and spreading could be to ask the women to express aspects of themselves of which they are proud. They could also express their accomplishments and positive qualities. A different option may be to ask the women to express the way they would like to be perceived. The verbalization, in combination with the movement expression of these experiences, may encourage the women to express positive qualities as well as the growth they would like to make within themselves on a mind and body level.

When expressing aspects of themselves that were related to feeling positive and proud, the data showed that the women in this study accessed the shaping qualities of rising and spreading. Encouraging the women to draw on times when they feel positive and hopeful may therefore influence them to naturally access these shaping qualities within themselves.

Continually increasing their mind/body connections to positive emotional experiences may then assist the women to connect more deeply to positive perceptions of themselves. Developing increasingly positive perceptions of themselves may therefore improve their ability to recognize strength within themselves. Recognizing their strength and abilities with the support and guidance during the course of long-term counseling may consequently improve their self-esteem over time. An increase in self-esteem may likewise give way to new strength within themselves. As research has shown, increased self-esteem decreases one's tendency to internalize their mistakes and experience shame. Therefore, gaining increasing strength and self-esteem through the ongoing commitment of body-based counseling services may over time lead to diminished feelings of shame and serve to decrease the women's gravitation toward addictive behavior.

Limitations of Study

When undergoing qualitative research, it is not possible to eliminate all the variables within the study that may bias or influence the results. Due to this fact, there will inevitably be limitations within the research. First of all, my research methodology is qualitative; therefore it is biased due to the fact that it is my subjective interpretation of the results.

Further limitations of my study include the fact that women in my groups were at different stages in their recovery. In addition, I did not lead groups with all of the women from the beginning until the end of their treatment. The size of my groups also fluctuated over the

course of my study. This limited the data to a sample of women who did not experience their entire recovery process. Two of the women dropped out of treatment and one woman finished her treatment before the groups were completed. Therefore, a complete understanding of the progress of the recovery and emotional experience of all the women, from beginning to end, was not possible.

Within my movement observations, I only examined movement during the moments when the women conveyed experiences associated with their recurring life themes. Basing my movement observations on the moments the women presented these recurring themes limited the sample from which I was basing my observations. Ultimately, this did not allow various other movement themes from potentially being uncovered at other moments in the DMT groups.

Additionally, my conclusion that shaping qualities was the primary movement theme presented by the women was influenced by the fact that I did not engage the women in full body movement throughout the groups. If I had engaged in full body movement with the women, this would have allowed for additional movement themes to be revealed. Therefore, the conclusion that shaping qualities were the primary movement themes the women presented was directly influenced by the fact that the women were not engaged fully through their bodies during the groups.

Finally, due to the fact that this study focused on assessment of shame verbally and nonverbally, examining movement interventions was outside the realm of this study. If I would have examined my movement interventions, I may have been able to gather more extensive information about the benefits of the movement the women displayed in relationship to their shame and recovery process. Therefore, the examination of movement interventions is a suggestion for further research.

Further Research Questions

Addressing the limitations within this study leads to a discussion of the further research questions this study has presented. This study supported the existing research that shame is a primary emotion women experience during their addiction as well as during their recovery. Considering this information, I believe it is important to continue the exploration of the contributing factors to shame and addiction. Furthermore, I believe it is crucial to understand how we as clinicians can address shame as well as the other gender specific issues, which affect addiction and shame in women. The following are some of the questions I have developed throughout this thesis process, which could be used for further research.

1. Can dance/movement therapy increase women's self worth and reduce their shame?
2. How can shame in women be addressed and treated in recovery using DMT interventions?
3. Will increasing women's self-esteem reduce their shame? How can clinicians accomplish this?
4. Will reducing a woman's shame reduce her risk for addiction?
5. What programs do current recovery centers incorporate to treat women's addiction? Are they specific to women's needs?
6. Do current treatment models have follow-up care for women? What does this include? Are they successful? How many clients return for treatment?
7. Can family support systems help reduce shame in women? If so, how can this be done?

This study could not answer the questions I have just presented. It was through the analysis and writing of the results that these questions presented themselves. Therefore, they

have become further questions for continued research on the topic of women's shame and their recovery process from addiction.

Summary

The research questions for this study were: "Is shame a predominant emotion experienced by women in recovery for drugs and alcohol?" and "How is shame expressed verbally and non-verbally in women during their treatment process of addiction?" The purpose of this thesis project was to identify the emotional experiences of women who were in treatment for addiction and determine if shame was a predominant emotion. Furthermore, knowledge about the emotional experiences of the women to understand the contributing factors to their shame and addiction was revealed.

The findings of this study revealed that shame was in fact a primary emotion experienced by the women in the DMT groups, while in recovery from drugs and alcohol. As a result of their addiction, the women predominantly experienced shame as related to the relationships in their lives. The women also placed most of the responsibility of their addiction on themselves as evidenced by their focus on self when establishing goals during their recovery. Contributing factors to their shame and addiction were the relationships in their lives, their parental responsibilities and their disconnection from themselves.

Within this thesis project, the most salient movement themes the women expressed, while discussing their recurring life struggles, were shaping qualities. Specifically, the shape qualities the women displayed while expressing the emotion of shame were sinking and enclosing. Additionally, the women presented the shaping qualities of rising and spreading when expressing positive growth within themselves.

Conclusively, the work of dance/movement therapists can be informed through the psychological implications of the shaping qualities that were displayed. It was revealed that shame was often expressed with the corresponding shaping qualities of sinking and enclosing. Additionally, the shaping qualities of rising and spreading were associated with positive aspects of themselves. Therefore, shifting women from the sinking and enclosing shaping qualities into rising and spreading may improve women's overall view of themselves. Increasing women's ability to access their body through breathing exercises, body awareness and grounding exercises could also be important aspects of addressing shame within their recovery process. Increasing their opportunities for self-expression through movement may be a valuable opportunity for improving awareness of self, self-assertion and self-esteem. Furthermore, these practices could strengthen women's connection to self, which was a goal the women identified in their recovery process.

In addition to the research questions asked during this study, new questions have been inspired such as, can DMT increase a women's self worth and reduce their shame? If so, how can shame in women be addressed and treated in recovery using DMT? Lastly, will reducing a woman's shame reduce her risk for addiction?

References

- Ahmed, E. (2001). Shame management: Regulating bullying. In E. Ahmed, N. Harris, J. Braithwaite, & V. Braithwaite (Eds.), *Shame management through reintegration* (pp. 211-311). Cambridge: University of Cambridge.
- Alcoholics Anonymous World Services, Inc. (1976). *Alcoholics Anonymous* (3rd ed.). NY: Author.
- American Dance Therapy Association. (2010, October 1). *What is DMT?* Retrieved from <http://www.adta.org/>
- Articles, M. (2010, September 27). *The difference between guilt and shame*. Retrieved from <http://www.differencebetween.net/language/difference-between-guilt-and-shame/>
- Atherton, J. S. (2010, October 1). *Doceo; Shame-culture and guilt-culture*. Retrieved from http://www.doceo.co.uk/background/shame_guilt.htm
- Babcock, M. L., & Connor, B. (1981). Sexism and treatment of the female alcoholic: A review. *Social Work, 26*(3), 233-238.
- Baker, F.A., Dingle, G.A., & Gleadhill, L.M. (2007). Music therapy and emotional exploration: Exposing substance abuse clients to the experiences of non-drug-induced emotions. *The Arts in Psychotherapy, 34*, 321-330.
- Beckman, L. J. (1993). Alcoholics anonymous and gender issues. In B. S. McGrady & W. R. Miller (Eds.), *Research on Alcoholics Anonymous: Opportunities and alternatives* (pp. 233-50). New Brunswick, NJ: Rutgers Center of Alcohol Studies.
- Boyd, M.R., & Mackey, M.C. (2000). Running away to nowhere: Rural women's experiences of becoming alcohol dependent. *Archives of Psychiatric Nursing, 14*, 142-149.
- Breslin, K.T., Malone, S.B., & Reed, M.R. (2003). A holistic approach to substance abuse

- treatment. *Journal of Psychoactive Drugs*, 35(2), 247-251.
- Chaiklin, H. & Chaiklin S. (2004). Dance/movement therapists in action. In C. F. Berrol, & R. F. Cruz (Eds.), *The case study* (pp. 69-89). Springfield, IL: Thomas Books Publishing.
- Chudley, A. E., Conry, J., Cook, L. L., LeBlanc, N., Lock, C. N., & Rosales, T. (2005). Fetal alcohol spectrum disorder: Canadian guidelines for diagnosis. *Canadian Medical Association Journal*, 172(5 Suppl. S), S1-S21.
- Combs, K. L. (2005). *A case study with an adolescent girl: A relationship created through dance/movement therapy and explored through relational cultural theory*. Unpublished master's thesis, Columbia College Chicago, Chicago.
- Covington, M. V. (1985). Anatomy of failure-induced anxiety. The role of cognitive mediators. In R. Schwarzer (Ed.), *Self-related cognitions in anxiety and motivation* (pp.59-98). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Dearing, R. L., Stuewig, J., & Tangney, J.P. (2005). On the importance of distinguishing shame from guilt: Relations to problematic alcohol and drug use. *Addictive Behaviors*, 30(7), 1392-1404.
- Fisher, B. (1990). DMT: Its use in a 28-day substance abuse program. *The Arts in Psychotherapy*, 17(4), 325-331.
- Fossum, M. A., & Mason, M. J. (1986). *Facing shame: Families in recovery*. New York: W. W. Norton.
- Fuhlrodt, R. L. (1990). *Psychodrama: Its application to ACOA and substance abuse treatment*. East Rutherford, NJ: Perrin.
- Ghiselin, B. (1954). *The creative process: A symposium*. Berkeley: University of California

Press.

Hackney, P. (2002). *Making connections: Total body integration through Bartenieff fundamentals*. New York, NY: Routledge.

Johnson, L. (1990). Creative arts therapies in the treatment of addictions: The art of transforming shame. *The Arts in Psychotherapy*, 17(3), 299-308.

Kaskutas, L.A. (1996). A road less traveled: Choosing the “women for sobriety” program. *Journal of Drug Issues*, 2, 77-94.

Lewis, H. B. (1971). *Shame and guilt in neurosis*. New York: International Universities Press.

Lester, S. (1999). *An introduction to phenomenological research*. Retrieved from <http://www.sld.demon.co.uk/resmethy.pdf>

Lindsay-Hartz, J., de Rivera, J., & Mascolo, M. (1995). Differentiating guilt and shame and their effects on motivation. In J. P. Tangney & K. W. Fischer (Eds.), *Self-conscious emotions: Shame, guilt, embarrassment, and pride* (pp. 274-300). New York: Guilford.

Malpede, J. M. (2005). *What is the experience of shame and the impact of self-disclosure on the healing process of women involved in a gender-specific addiction program?* Unpublished doctoral dissertation, The Union Institute and University, Ann Arbor, MI.

Maruna, S., & Ramsden, D. (2001). Living to tell the tale: Redemption narratives, shame management, and offender rehabilitation. *Healing Plots; The Narrative Basis of Psychotherapy*, 12(2), 129-149.

Matheson, J.L., & McCollum, E.E. (2008). Using metaphors to explore the experiences of powerlessness among women in 12-step recovery. *Substance Use and Misuse*, 43(8/9), 1027-1044.

McGrady, B.S., & Miller, W. R. (1993). *Research on Alcoholics Anonymous: Opportunities and*

- alternatives*. New Brunswick, NJ: Rutgers Center on Alcoholic Studies.
- Milliken, R. (1990). Dance/movement therapy with the substance abuser. *The Arts in Psychotherapy*, 17(4), 309-317.
- Morrison, J. (2006). *DSM-IV made easy: The clinician's guide to diagnosis*. New York: The Guilford Press.
- Moustakas, C. (1994a). *15 Methods of data analysis in qualitative research*. Retrieved from <http://qualitative-research.net/ratcliffs.net/15methods.pdf>
- Moustakas, C. (1994b). *Phenomenological research methods*. Thousand Oaks, CA: Sage Publications.
- Mulia, N., Schmidt, L., Bond, J., Jacobs, L. & Korcha, R. (2008). Stress, social support and problem drinking among women in poverty. *Addiction*, 103(8), 1283-1293.
- Murray-Lane, B.M. (1995). Walls of addiction. In F.J. Levy, J. Pines & F. Leventhal. (Eds.), *Dance and other expressive art therapies: When words are not enough* (pp.93-99). New York: Routledge Publishing.
- Nathanson, D.L. (1992). *Shame and pride: Affect, sex and the birth of the self*. New York: W. W. Norton.
- National Association of Cognitive Behavioral Therapists. (2010, October 1). *Cognitive behavioral therapy*. Retrieved from <http://www.nacbt.org/whatiscbt.htm>
- National Institute on Drug Abuse. (2007, October 25). *A cognitive-behavioral approach: Treating cocaine addiction*. Retrieved from <http://drugabuse.gov/TXManuals/CBT/CBT4.html>
- Office of National Drug Control Policy. Girls and Drugs. (2006). A new analysis: Recent trends, risk factors and consequences. Washington, DC: U.S. Department of Justice.

- Perlmutter, M. (1992). The dance of addiction. *American Journal of Dance Therapy*, 14(1), 41-48.
- Rhodes, R., & Johnson, A. (1994). Women and alcoholism: A psychosocial approach. *Affilia* 9, 145-156.
- Rose, S. (1995). Movement as a metaphor: Treating chemical addiction. In F.J. Levy, J. Pines & F. Leventhal (Eds.), *Dance and other expressive art therapies: When words are not enough* (pp. 101-107). New York: Routledge Publishing.
- Schmais, C. (1998). Understanding the dance/movement therapy group. *American Journal of Dance Therapy*, 20(1), 23-33.
- Sharp, B. D. (2000). *Changing criminal thinking: A treatment program*. Lanham, MD: American Correctional Association.
- Stofle, G.S. (1999). The mortality of alcoholism mental health net - perspectives. A mental health magazine. Retrieved from http://www.mentalhelp.net/poc/view_doc.php?type=doc&id=381
- Weatherby, C. (2004). *Reinhabiting the body: Dance/movement therapy as a therapeutic approach for women survivors of domestic violence*. Unpublished master's thesis, Columbia College Chicago, Chicago.
- Wermser, L. (1994). *The mask of shame*. Northvale, NJ: Jason Aronson.
- Wiechelt, S.A. (2008). Introduction to the special issue: International perspectives on women's substance use. *Substance Use and Misuse*, 43(8/9), 973-977.
- Wiechelt, S., & Sales, E. (2001). The role of shame in woman's recovery from alcoholism: The impact of childhood sexual abuse. *Journal of Social Work Practice in the Addictions*, 12(3), 133-157.

Wiklund, L. (2008). Existential aspects of living with addiction-- Part I: Meeting challenges.

Journal of Clinical Nursing, 17(6), 2426-2434.

Appendix A

Definition of Terms:

Addiction

The term addiction refers to a mental health issue described by the DSM as substance dependence (Morrison, 2006). The substance use within this thesis refers to the use of drugs and alcohol. The criterion necessary to meet a diagnosis of substance dependence specifies a type of dependence that includes behavioral, physiological and cognitive symptoms. The women in this thesis meet at least three of these criteria necessary to warrant a diagnosis of substance dependence. According to the DSM, this is described as “the maladaptive pattern of substance use that leads to clinically important distress or impairment, as shown in a single 12-month period” (Morrison, 2006, p. 69). These criteria include an increased tolerance for the substance. The patient experiences withdrawal from the substance or uses the substance to relieve withdrawal. The patient uses the substance in an amount or duration of use that is often greater than intended. The patient attempts without success to control or reduce substance use. The majority of the patient’s time is spent using the substance, recovering from its effects, or trying to obtain it. The patient reduces or abandons important work, social, or leisure activities because of substance use. The patient continues to use the substance, despite knowing that it has probably caused ongoing physical or psychological problems.

Body scan

The term body scan will be used to describe the process of bringing deeper awareness and connection to one’s body parts beginning from the crown of their head and ending at their toes.

Cognitive Behavioral Therapy

Cognitive-behavioral therapy (CBT) is based on the idea that our thoughts cause our feelings and behaviors; not external things, like people, situations and events. The benefit of this theory is that we can change the way we think to feel/act better even if the situation does not change (National Association of Cognitive Behavioral Therapists, 2010).

Conscious deep breathing

The term conscious deep breathing will be used to describe the process of bringing awareness to one's breath. Furthermore, this awareness can assist in deepening one's breath in order to experience an increased connection to their body, bringing about a calm state of relaxation.

Dance/movement therapy (DMT)

Dance/movement therapy is the psychotherapeutic use of movement to promote emotional, cognitive, physical and social integration of individuals (American Dance Therapy Association, 2010).

Grounding exercises

The term grounding exercises will be used to describe the process of connecting one's body into the ground through a connection of his or her feet to the floor. This connection increases a feeling of stability, balance and support within oneself.

Guilt

The term guilt will be used to describe the emotion felt when the women recognize that an act they committed was wrong and consequently felt badly about that act (Articles, 2010). If a person has high self-esteem they are more likely to separate themselves from the bad act and simply feel guilt over that action. If others treat the act and individual as separate, then the

individual can feel guilt and make amends for their wrongdoings (Atherton, 2010). Therefore, feelings of guilt can motivate the individual toward repairing or changing their situation (Dearing, et al., 2005), affect positive behaviors or social change (Atherton, 2010). Consequently, “guilt-proneness has been shown to have a negative relation to alcohol and drug problems” (Dearing et al., 2005, p. 1396).

Holistic

The term holistic will be used to refer to a practice that considers the entire person including mind, body and spirit.

Negative Behavior

The term negative behavior will be used to describe, from the women’s perspective, an action or poor choice they made which caused another person pain or grief.

Shame

The term shame will be used to describe the emotion when the women recognize that an act they committed was wrong and subsequently internalized the bad act, believing they were a bad person as a result of their negative behavior (Articles, 2010). Shame is described as a betrayal of the global or gestalt self because it is a threat to the whole framework of one's identity (Wermser, 1994). It involves a negative feeling about the self in response to some wrongdoing (Lewis, 1971). Shame is thought to encompass feelings of inadequacy, inferiority, humiliation, dishonor, and a sense of despair and deep suffering (Ahmed, 2001), which can be painful and paralyzing, affecting one's sense of self (Lindsay-Hartz, de Rivera & Mascolo, 1995). These feelings of shame may also invoke a self-defeating cycle of negative affect (Lindsay-Hartz, de Rivera & Mascolo, 1995). Consequently, shame-prone individuals are vulnerable to a variety of difficulties, including psychological problems and low self esteem.

Because the focus of shame is on the defective self, this painful emotion also has the effect of impairing empathy, which can result in a wide range of interpersonal difficulties (Dearing et al., 2005).

Shape Qualities

Shape qualities give information about the attitudinal process of changing the shape of the body. Every movement is an action of shape change from closing to opening or opening to closing, even if the movement is very subtle. The accompanying shape qualities include rising and sinking, spreading and enclosing, and advancing and retreating (Hackney, 2002).

Using

The term using will refer to the women's use of drugs and alcohol as a means to alter their state of mind and escape from the reality of their lives. This use impinges upon their ability to maintain a healthy, balanced life.

Appendix B



Informed Consent Form Consent Form for Participation in a Research Study

Title of Research Project: The Emotional Road to Recovery: The Mind & body Experience of Women's Recovery Process.

Principal Investigator: Nicole DiBacco

Faculty Advisor: Laura Spencer Allen

Chair of Thesis Committee: Lenore Hervey

INTRODUCTION

As part of Nicole DiBacco's thesis project, you are invited to participate in a project that will describe the emotional experience of women who are in treatment for addiction. This consent form will give you the information you will need to understand why this study is being done and why you are being invited to participate. It will also describe what you will need to do to participate and any known risks, inconveniences or discomforts that you may have while participating. You are encouraged to take some time to think this over, but we will need an answer in no more than 5 days. You are also encouraged to ask questions now and at any time. If you decide to participate, you will be asked to sign this form and it will be a record of your agreement to participate. This process is called 'informed consent.' You will receive a copy of this form for your records.

You are being asked to participate because you are a woman recovering from addiction. Your participation will make it possible for students and dance/movement therapists to gain a greater understanding about the experiences of women undergoing treatment for addiction. As a result, this will help counselors serve women like you in the future.

PURPOSE OF THE STUDY

The purpose of this research study is to gain a greater understanding about the experiences of women who are in treatment for addiction.

PROCEDURES

If you agree to participate in this study, you will be asked to do the following:

- Participate in 4-6 videotaped dance/movement therapy groups.
- These groups will take place for 4-6 weeks
- They will take place in the women's program day room.
- The groups will begin in early June.

- Each group will last one hour.
- The total time required for this study will be four to six hours.

POSSIBLE RISKS OR DISCOMFORT

The potential risks or discomforts may be that you could potentially experience emotional discomfort if you connect to painful memories or deep emotional content during the groups. This is typical of the therapies received as part of your intensive inpatient treatment. I will offer my support and an opportunity to talk about your experiences during the group. In addition to this, your individual counselor as well as the other counselors and staff are available to offer you more support if needed. Another discomfort may be related to the movement aspect of the group. There is a chance that engaging in movement will be uncomfortable for you. If this is the case, you will be given the time and space you need within the group to become more comfortable. You will not be forced or required to do anything that makes you uncomfortable. The physical risks of participating in dance/movement therapy are similar to exercising.

POSSIBLE BENEFITS

The possible benefits of being in this study may include decreased stress, increased social interaction, increased coping skills, increased self-awareness, self-expression and increased ability to work with others. There may of course be many further benefits you will receive from these groups. This will be determined by the level of group involvement and willingness and commitment to working on your personal issues related to your addiction.

CONFIDENTIALITY

The following procedures will be used to protect the confidentiality of your information:

1. I, the researcher will keep all study records locked in a secure location.
2. My supervisor and I will be the only people to view the videotapes.
3. Any audio and videotapes will be destroyed after 1 year.
4. All electronic files containing personal information will be password protected.
5. Information about you that will be shared with others will be given a different name to help protect your identity.
6. I will be the only person who will have access to the original data.
7. At the end of this study, I will present the findings to the Columbia College Chicago through a scholarly written documentation of the groups.
8. This documentation will help future students and dance/movement therapists understand the emotional experience of women in recovery
9. You will not be identifies in any publications or presentations.
10. I will not disclose any personal information about what you say in the group, to others outside of this group and I will ask all participants to do the same. Although, I cannot control what each participant will do outside of group, therefore, I cannot ensure complete confidentiality.

RIGHTS

Being a research participant in this study is voluntary. You may choose to withdraw from the study at any time without penalty. You may also refuse to participate at any time without penalty.

You have 5 days to make a decision. We will be happy to answer any question(s) you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact the principal investigator, Nicole DiBacco at XXXXXXXXXXXX or the faculty advisor Laura Allen at XXXXXXXXXXXX If you have any questions concerning your rights as a research subject, you may contact the Columbia College Chicago Institutional Review Board staff (IRB) at 312.369.7384.

COST OR COMMITMENT

You will be asked to participate in 4-6 dance/movement therapy groups.

The total time commitment for this study is four to six hours of participation.

PARTICIPANT STATEMENT

This study has been explained to me. I volunteer to take part in this research. I have had opportunity to ask questions. If I have questions later about the research or my rights as a research participant, I can ask one of the contacts listed above. I understand that I may withdraw from the study at any time without penalty. I will receive a copy of this consent form.

Participant/Parent/Guardian
Signature:

Print Name:

Date:

Signature of Person
Obtaining Consent

Print Name:

Date:

Principal Investigator's
Signature

Print Name:

Date

Appendix C



Authorization Release of Information for Research

I, _____, whose social security number is _____,
have consented to participation in the following research study:

In connection with this study, I understand that the following information may be used or
disclosed as necessary for research purposes:

I authorize release of this information by Cornell Interventions for research purposes.
I understand that I have a right to revoke this authorization, in writing, at any time by
sending written notification to the Facility Director at Cornell Interventions-Southwood.
I further understand that a revocation is not effective to the extent that action has been
taken in reliance on it and that Cornell Interventions may continue to disclose PHI
obtained prior to my revocation as necessary to maintain the integrity of the research
study. Unless sooner revoked, this authorization expires at the end of the research study.

I further understand that my signing this authorization form is a condition to participation
in the research study and to receiving any research-related treatment.

I understand that my right to access my PHI created or obtained in the course of research
that includes treatment may be temporarily suspended for as long as the research is in
progress. My right of access will be reinstated upon completion of the research.

The recipient of the PHI may only disclose it back to Cornell Interventions and may not
identify any individual patient in any report of that research or otherwise disclose patient
identities.

I further authorize Cornell Interventions to follow up with me for research purposes.

Signature of Client/Research Participant

Date

Signature of Witness (Primary Counselor)

Date

Signature of Researcher

Date